

PRESCRIPTION MISMANAGEMENT AND THE RISK OF VETERAN SUICIDE

HEARING

BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS

OF THE
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CONTENTS

Wednesday, June 10, 2015

| | Page |
|---|------|
| Prescription Mismanagement and the Risk of Veteran Suicide | 1 |
| OPENING STATEMENTS | |
| Mike Coffman, Chairman | 1 |
| Ann Kuster, Ranking Member | 2 |
| WITNESSES | |
| Carolyn Clancy, M.D., Interim Under Secretary for Health, Department of Veterans Affairs | 7 |
| Prepared Statement | 33 |
| Accompanied by: | |
| Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management Service, Veterans Health Administration | |
| And | |
| Mr. Harold Kudler, M.D., Chief Consultant, Mental Health Services, Veterans Health Administration | |
| Mr. Randall Williamson, Director, Healthcare Issues, Government Accountability Office | 10 |
| Prepared Statement | 48 |
| Ms. Jacqueline Maffucci, Ph.D., Research Director, Iraq and Afghanistan Veterans of America | 11 |
| Prepared Statement | 63 |
| STATEMENT FOR THE RECORD | |
| The American Legion | 67 |
| Deliverable | 73 |

PRESCRIPTION MISMANAGEMENT AND THE RISK OF VETERAN SUICIDE

Wednesday, June 10, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The subcommittee met, pursuant to call at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [chairman of the subcommittee] presiding.

Present: Representatives Coffman, Lamborn, Roe, Benishek, Heulskamp, Kuster, O'Rourke, Rice, and Walz.

Also Present: Representative Miller.

OPENING STATEMENT OF CHAIRMAN MIKE COFFMAN

Mr. COFFMAN. Good morning. This hearing will come to order. I want to welcome everyone to today's hearing titled Prescription Mismanagement and the Risk of Veteran Suicide.

Before we begin, I would like to ask unanimous consent that a statement from The American Legion be entered into the hearing record. Hearing no objection, so ordered.

This hearing will examine the relationship between veterans prescribed medications as a result of their mental health and the increased suicide rate among veterans.

In a report issued in November 2014, which included in part evidence uncovered by the O&I Subcommittee, GAO examined VA's data on veterans with major depressive disorder including the extent to which they were prescribed medications, the extent to which they received proper care, and whether VA monitored that care, and the information VA requires VAMCs to collect on veteran suicides.

It is now clear that VA is not even aware of the population of veterans with major depressive disorder due to inappropriate coding by VA physicians. As a result, VA cannot determine if veterans are receiving care consistent with the clinical practice guidelines.

These guidelines are crucial to the treatment of mental disorders as they are designed to provide the maximum relief from the debilitating symptoms associated with mental health. It is imperative that our veterans receive the proper care and follow-up when receiving mental healthcare, especially when they are being prescribed various medications.

What has also become clear is that VA is receiving and reporting inaccurate and inconsistent data regarding veteran suicides. This severely impacts and limits the department's ability to accurately

evaluate its suicide prevention efforts and identify trends in veteran suicides.

Not only did the committee conduct a hearing in 2010 on this same issue, but since then, there have been countless media stories of veterans being over-medicated or experiencing adverse drug reactions and not receiving the proper care, the proper follow-up, or the proper monitoring, and the all too common result of suicide.

One story told of a veteran who went into a hospital seeking care, but after being, quote, unquote, lost in the system ended up dying by suicide right in the facility. We will also hear other similarly tragic stories today that highlight the tremendous problems occurring with VA for years and continuing today with regard to treatment of veterans with mental health concerns, adequate oversight of treatment programs, and more importantly the actions taken to ensure veterans who are prescribed countless medications receive proper follow-up.

Currently VA has approximately ten different programs dealing with prescription medication and suicide prevention issues, but it does not appear that any of these programs interact with one another. No one is talking to anyone else. How can we ensure that the veterans are getting the proper care, the proper follow-up, and the proper advice if the right hand doesn't know what the left hand is doing?

I think it is more appropriate to say based on the statistics from the GAO report and the numerous media stories that VA is just throwing out a bunch of different ideas and programs hoping one of them will stick and they can claim they have solved the problem. This is unacceptable. We need to know exactly what VA is doing to change this pattern and what is it doing to improve protection of veterans.

What is a real way forward? Who will be held accountable for mistakes that have already been made and have cost veterans their lives? Who will stand up and take responsibility for making a change? It is time for answers. It is time for change.

With that, I now yield to Ranking Member Kuster for any opening remarks she may have.

OPENING STATEMENT OF RANKING MEMBER ANN KUSTER

Ms. KUSTER. Thank you, Mr. Chairman.

And good morning to our panel. Thank you for being with us.

This morning, we are addressing a complex healthcare policy issue affecting veterans and over 100 million American adults. The statistics on veterans experiencing chronic pain are staggering. Over 50 percent of all veterans enrolled and receiving care at VA medical facilities experience chronic pain, with over a half a million veterans managing pain with prescribed opioids.

As a Nation and certainly in my district and throughout the northeast, we face what can only be described as an opioid abuse epidemic. The Centers for Disease Control and Prevention has termed opioid abuse the worst drug addiction epidemic in the country's history, killing more people than heroin and crack cocaine.

In addition to the issue of pain management and the problems of addiction, we must remember that many veterans who experience chronic pain also suffer from mental health disorders such as

posttraumatic stress and traumatic brain injury. Therefore, it is vital that the VA has in place the proper oversight mechanisms to monitor the safe use of opioids for managing veterans' pain.

I am particularly concerned about veterans at risk of self-medication and addiction being prescribed opioids for pain management. We know from multiple inspector general and GAO reports that the VA has struggled to properly monitor prescribed opioids and the mental health of its patients. And I am concerned that a potential deadly mix of opioid use, mental health disorders, and lack of oversight is contributing to our high rate of veteran suicide.

The newest Drug Enforcement Agency regulations that require veterans to see a clinician monthly for a refill of opioid pain medication creates an additional burden on veterans who have difficulty accessing care at VA medical facilities, leaving some veterans to suffer from extreme pain and experience opioid withdrawal symptoms when they are unable to schedule an appointment to refill.

This hearing provides us with the opportunity to begin to seriously examine whether the benefits of managing veterans' pain with opioids is outweighed by the risk and side effects experienced by veterans and the VA healthcare system's struggle to properly monitor opioid use.

During this hearing, I would like to hear from our witnesses how we can better address safe and effective treatment of veterans while ensuring that care management is not forgotten.

I would like to discuss whether a higher level of informed consent is needed to ensure veterans and their families understand the risks and side effects before choosing to manage pain with opioids and whether the VA is properly coordinating mental health and suicide prevention programs with VA medical facility clinicians and employees responsible for monitoring patient opioid use.

I am also interested in alternative pain management and as I get to my comments later, I will talk about what is happening at the White River Junction VA in bringing down the rate of opioid prescriptions and how we can help get ourselves out of this problem, out of this cycle and address the veterans, to serve their needs without putting them and their families at risk.

And, finally, I would like to discuss what is being done to reduce long-term opioid use and treat the underlying conditions causing chronic pain so that veterans are able to live a better quality of life.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

I will introduce our witnesses in just one moment, but I ask that the witnesses stand and raise their right hand.

[Witnesses sworn.]

Mr. COFFMAN. Please be seated.

I would like to recognize the Honorable Jeff Miller, Chairman of the full Veterans' Affairs Committee, who has joined us on the dais.

Welcome, Chairman Miller. You have the floor.

Mr. MILLER. Thank you very much, Mr. Chairman.

To the Ranking Member, Ms. Kuster, thank you for the good work that this subcommittee has been doing over the last several years.

If I might, instead of giving a typical opening statement, I want to ask Ms. Clancy a couple questions because I need to move on to another appointment.

And I believe, Dr. Clancy, that you have been made aware that I am going to be asking a couple of questions, albeit a little bit out of order. And I want to talk specifically about Bradley Stone.

We know that he was seen by his VA psychiatrist a week prior to his commission of multiple murders and subsequently dying of suicide. He was on many, many prescription drugs and had alerted VA, as I understand it, to mental health and physical difficulties in the weeks leading up to the incident.

But it appears that VA said he showed no signs of suicidal or homicidal ideations. And I would like to know how did VA come to that conclusion that the veteran was okay, and I say that in quotes, when he was reporting all of these feelings prior to the incident.

Dr. CLANCY. In general, people would come to that conclusion by asking the veteran a series of questions about were they having thoughts of harming themselves and so forth to get some assessment of suicide risk. So my conclusion, if the clinician said, would be that the veteran answered, gave negative responses to them.

Mr. MILLER. Okay. On the 24th of April of this year, I asked the department if it would confirm whether or not they had provided the full committee with all of the files related to Bradley Stone. To date, I have not received a response. So, again, I ask you, has VA provided this committee with all of the files on Bradley Stone?

Dr. CLANCY. I had been told that VA had provided the committee with the files with some redactions and had also provided—offered an in-camera review. And the redactions were about Social Security numbers and some information that was about sensitive details about the living family members of Bradley Stone and, again, offered to discuss that with the committee in camera.

Mr. MILLER. And, again, as I have stated in every single letter that I have sent to the department requesting information, an in-camera review is not acceptable. That may be what you want to provide us, but that is not at all acceptable. And so, you know, the staff has informed you and the department that I was going to ask particular questions.

So, again, I ask you, has all of the information—and I would go back to I sent the secretary a letter on April 24th where I referred to Ms. Diana Rubens, Director of the Regional Office, on April 22nd saying that the Philadelphia Regional Office had provided everything related to Mr. Stone's file. Her response was unequivocally yes.

And so I am taking from your comment today then everything that she provided to the central office, the central office has now provided to this committee?

Dr. CLANCY. Since I'm under oath, I'm going to be very careful. I don't—I can't speak for what Diana Rubens is telling you. I have been informed directly by our lawyers that we have provided this committee with all the records with the redactions that I mentioned before, again, Social Security numbers and some sensitive details about the living family members of Mr. Stone.

Mr. MILLER. Okay. I want to for the record, Mr. Chairman and Dr. Clancy, I know for a fact that VA has withheld hundreds of pages related to the Bradley Stone file. And so with that, I would say that we have requested all the documents every way we know how.

So I will ask you one more time, can I expect the department to deliver the complete records by the end of this week?

Dr. CLANCY. I will take that back and I will verify what I've been told that we have given this committee everything except for redactions as I noted earlier.

Mr. MILLER. Okay. I can assure you it is not redacted. It is missing, completely missing.

Dr. CLANCY. I will bring that message back.

Mr. MILLER. We also expect you to deliver the behavioral health autopsy unredacted by the end of the week. And I have told VA and I will reiterate it again an in-camera review is not acceptable.

And I ask will you commit that all the documents that I have requested will be provided by the end of this week?

Dr. CLANCY. The behavioral health autopsy is a unique feature of what we do at VA healthcare for veterans. Rather than having a private limited to the people at the facility, root cause analysis or deep dive of what happens when a veteran takes his or her own life, this is something that we have centralized so that we can learn across the system what kinds of factors might have precipitated the suicide, what could we have done differently or better, and it also involves a conversation with the family members of that veteran, none of whom have been told that we would be thoughtfully sharing their details with members of the committee.

And we think that it will have a chilling effect on family members sharing sensitive details and are very, very uncomfortable with sharing the behavioral health autopsy.

Mr. MILLER. Thank you very much for that educational opportunity.

I refer to you again the fact that we are the legislative branch. You are the executive branch. We have complete and constitutional oversight over the department and unredacted information or anything that is done within your department that you choose to withhold, we will subpoena it if necessary.

Can I expect to have this information delivered by Friday?

Dr. CLANCY. I will take that back, Mr. Chairman.

Mr. MILLER. Thank you very much.

And also, I would also like to add on a positive note I was in Cincinnati yesterday. I was in Dayton the day before. I want to thank you for the good job that we see being done at the facilities there. There has been a great change in Dayton in specifics. And I enjoyed the opportunity to spend a couple of hours with the people in Cincinnati.

We do focus on a lot of the negative and the press likes to focus on that as well, but I want to commend you on some of the great things and I would hope that some of the good things specifically at Cincinnati would be shared throughout VHA and the rest of the department.

Thank you very much.

Dr. CLANCY. Well, if I might for one second, Mr. Chairman, first thank you very much for that. I know how hard those people work. Cincinnati is actually the hub of expertise in intensive care for our system, so they actually provide remote assistance to——

Mr. MILLER. I had a chance to view it.

Dr. CLANCY. Did you?

Mr. MILLER. I sure did.

Dr. CLANCY. It's great. It really is.

Mr. MILLER. Thank you very much.

Mr. COFFMAN. One point, Dr. Clancy. The VA has turned over behavioral health autopsies to this committee before.

And so, Ranking Member Kuster.

Ms. KUSTER. Yes. I just wanted to say for the record as a healthcare attorney who has worked in this area for quite a long period of time in the realm of quality assurance and what the purpose of this type of quality assurance is about when you go back and look, it is intended for physicians and the medical team to grow and learn from these experiences.

And I am concerned at the impression that might be left with veterans and their families, particularly the family members that have been through the trauma of a suicide, that this information would be treated confidentially because these hearings, as we know, are televised. It is a very public setting.

And I think we should get to the bottom, but I don't want to do anything that would have a chilling effect on families that are sharing the most personal aspects. We already have such a strong stigma around mental health and about people seeking treatment. And I would be extremely concerned if we left the impression today that we are in some way digging into private affairs.

If there is information about living family members that is not relevant, it could be extremely personal. And I guess I just don't understand why we couldn't do that in a private setting or in a redacted way, why this committee would be trying to determine—and I am not speaking as to if you believe there are documents that have not been provided. That is a separate matter.

But I know that under our statutes in the state, confidential information in this quality assurance process is confidential and it is not to be shared. And the purpose of that is so that people will come forward. So that is my only comment.

Mr. COFFMAN. Mr. Chairman.

Mr. MILLER. Thank you very much, and I appreciate the expertise that you bring to this committee and to the subcommittee.

And you can rest assured, and I think you know that what we are trying to do is to hold people accountable. We are not trying to release any information that is personally identifiable. This is also a murder situation. It is a suicide which is very difficult, but a murder suicide.

And so I believe that while the VA is going through and doing this and attempting to find out where things may have broken down, the fact is we have gotten this information before from other incidents. This one is particularly grievous because of the murders that took place.

And I remind you that we are a federal body, not a state body. We are bound by the United States Constitution of which we are

given oversight of the executive branch and we are not bound by many of the laws, the HIPAA laws and other information to receive that information for us to be able to do our oversight in this. And it is not political.

Again, we are trying to get to the bottom of a very tragic event and we are trying to partner with the VA as well. And right now they are not being as open as they should be. There are documents that are clearly missing from the file, documents that I believe are damning documents and would put VA in a very negative light.

I understand that. But you can't remove those documents from the file just because it makes you look bad. And that is what we are trying to get at at this point.

But, again, I thank every member of this subcommittee for the job that you have been doing and look forward to continuing the good works.

But thank you, Ms. Kuster.

Mr. COFFMAN. Thank you, Mr. Chairman.

I ask that all other members waive their opening remarks as per the committee's custom. Hearing no objection, so ordered.

With that, I would now like to introduce our panel. On the panel, we have Dr. Carolyn Clancy, Interim Under Secretary for Health for the Department of Veterans Affairs; Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management Service, Veterans Health Administration; Dr. Harold Kudler, Chief Consultant, Mental Health Services, Veterans Health Administration; Mr. Randall Williamson, Director of GAO's Health Care Team; and Dr. Jacqueline Maffucci, Research Director for the Iraq and Afghanistan Veterans of America.

Dr. Clancy, you are now recognized for five minutes.

STATEMENTS OF CAROLYN CLANCY, INTERIM UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MICHAEL VALENTINO, CHIEF CONSULTANT, PHARMACY BENEFITS MANAGEMENT SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, and HAROLD KUDLER, CHIEF CONSULTANT, MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF CAROLYN CLANCY

Dr. CLANCY. Good morning, Mr. Chairman Coffman, Ranking Member Kuster, members of the committee. Thank you for the opportunity to discuss the overuse of medication in the provision of mental healthcare to veterans, particularly for those at risk of suicide.

One of our most important priorities at VA is to keep our veteran patients free from harm at all times. I am deeply saddened by the tragic outcome involving a veteran. So to families here today or watching this hearing who've lost a loved one, I want to express my sorrow and regret for your loss. I appreciate your sharing your experiences with us and will—we will honor your loved ones by learning from those experiences and improving care for veterans in the future.

We acknowledge up front that we have more work to do to reduce opioid use, meeting the increasing demands for mental healthcare, and prevent suicides. And we've taken significant actions to improve these areas in order to better serve veterans.

As Ranking Member Kuster said, chronic pain is a national public health problem. It affects about a third of the Nation's adult population and about half of veterans from recent conflicts.

As a result, a number of veterans and Americans rely on opioids for pain control and they can be effective for a while until the side effects become quite worrisome. And often mixed with other drugs, they can have additional adverse, unintended effects.

As you noted, Mr. Chairman, we've adopted a number of initiatives and tools to advance our goal of safe and effective pain management, making data about rates and doses of opioids as well as the other medications a veteran is taking visible at the network facility and most recently at the individual clinician level.

Starting this July 1, we will be expanding on a very successful pilot of an approach called academic detailing which essentially consists of one-on-one coaching for every single clinician prescriber in our system.

And in addition to information about effective use of medications, it also—this approach also works with clinicians to have the difficult conversations with veterans to help them try other alternatives for pain management and so forth.

I think it's important to note that many of the veterans we serve come to us as they're transitioning from military service on opioids and other medications and abrupt discontinuation is not possible or actually practical. But we have to continue to taper these doses.

We've seen some successes and as you might expect, those with the least amount of problems have tended to do better than those who are experiencing more severe pain.

Suicide among veterans is very complex and tragic. Those of us who have lost a loved one to suicide know the deep and lasting pain. We've worked diligently with our scientific partners to understand suicides among those veterans receiving VA care and among all veterans across the Nation.

We know that treatment works. We've identified many positive outcomes for veterans who are receiving our care. For example, the rate of repeat attempts at suicide among veterans who have attempted to take their own lives has declined quite a bit for veterans enrolled in our system.

Between 1999 and 2010, the suicide rate among middle-aged male veterans who use our system fell by 31 percent, at the same time that the suicide rate for middle-aged men who are not veterans or who are veterans who don't use our system actually rose during that time period.

The rate of suicide among women veterans is higher than other women in the general public, but women veterans who use our system actually are less likely to die from suicide when compared to other women veterans.

As you know, our research has allowed us to estimate that about 22 veterans die by suicide every day. What's less well-known is that 17 of those 22 do not receive treatment for care within the VA system. And I worry that some of the 17 are actually seen in our

system and are fearful about raising mental health concerns because of concerns about the stigma or privacy.

Suicide prevention efforts have to extend to veterans who may not seek assistance. And any veteran who needs help can come to any point of entry of care in our system and will be seen that day.

We've also increased targeted outreach efforts to veterans in communities throughout the country and we've made it easier for anyone to call the veterans crisis line. And in response to many suggestions from stakeholders, in the very near future, you'll be able to do that when you call one of our facilities directly. You won't have to hang up and call the line. You can just hit a number on the phone and that will directly transfer you.

I really want to express my appreciation to the Congress for the Clay Hunt Act and its passage which will expand our capabilities to help veterans. So thank you for that.

The importance of mental health treatments I don't think can be overstated. About 20 years ago in this country, we simply did not recognize how important a challenge mental healthcare is for all Americans.

At VA, we have embraced the problems that veterans from returning conflicts brought to us, whether that's various mental health problems, posttraumatic stress, traumatic brain injuries, and so forth. And in doing so, we have had to blaze some trails.

We have had to go ahead of what is going on in the rest of U.S. healthcare where utilization of mental health has been pretty dramatically curtailed or utilization controlled over the years. So that meant that we have had to work with public and private science partners to build the basic science, the epidemiological data, and population health expertise.

We have learned a lot. We've made significant gains and seen the successes of treating mental health problems, but we have so much to do to dispel the stigma linked to mental health issues.

You know, it wasn't that long ago that cancer inspired that kind of whispering. People didn't talk about it out loud because of fears and misinformation. And, frankly, we hope with your help and the help of many partners that soon we'll be able to eliminate that fear and misinformation associated with seeking mental healthcare. And in the meantime, we're focusing on creating an atmosphere of trust and privacy.

I want to just close by saying that we're committed to improving our existing programs, taking every available action to create new opportunities, and most importantly improving the quality of life for veterans. We're compassionately committed to serve those who have served. We're proud to have this honor and privilege.

And we're prepared to answer your questions and look forward to working with you until we get this right. Thank you.

[THE PREPARED STATEMENT OF CAROLYN CLANCY APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Dr. Clancy.

Mr. Williamson, you are now recognized for five minutes.

STATEMENT OF RANDALL WILLIAMSON

Mr. WILLIAMSON. Good morning, Mr. Chairman and Ranking Member Kuster. I am pleased to be here today to discuss our No-

vember 2014 report on VHA's efforts to monitor veterans with major depressive disorder referred to as MDD who were prescribed one or more antidepressants.

MDD is a major risk factor for suicide among veterans. It is a particularly debilitating mental illness often associated with severe depression and reduced quality of life. Also, I will discuss certain aspects of VHA's suicide prevention program.

Specifically I will discuss the incidences of MDD among veterans treated by VA, the extent that VAMC clinicians prescribe antidepressants to veterans with MDD and monitor antidepressant use, and data VAMCs are collecting and reporting on veteran suicides to inform VHA's suicide prevention efforts.

VHA data show that about ten percent of the veterans receiving VA healthcare were diagnosed with MDD and 94 percent of those veterans with MDD were prescribed one or more antidepressants. However, the estimate of veterans with MDD may be low because in reviewing a sample of medical records from selected VAMCs, we found that VAMCs did not always correctly report and record confirmed MDD diagnosis among veterans.

At six VAMCs, we reviewed a sample of veterans with MDD that were prescribed one or more antidepressants and found that they did not always receive recommended care for three important recommendations in the clinical practice guideline referred to as CPG that VA has—VHA has established to guide its clinicians in treating MDD.

For example, although the CPG recommends that a veteran's depressive symptoms be assessed using a standardized assessment tool at four to six weeks after initiation of antidepressant treatment, we found that for 26 of the 30 veterans in our sample VA clinicians did not use this assessment tool at or used it within the specified time frame.

While not mandatory for VAMC clinicians, CPG recommendations are based on evidence-based data from clinical trials, research, and other proven and reliable sources and are meant to enhance outcomes for veterans with MDD.

Moreover, VHA does not have a process at any level to systematically monitor the extent that VAMC clinicians deviate from CPG recommendations. With little, if any, visibility over whether the care provided is consistent with the CPG, VA is unable to ensure that deviations from recommended care are identified and evaluated and whether appropriate actions are taken to mitigate potential significant risk to veterans.

Finally, we found that demographic and clinical data in VA's—VA—VAMCs collect on veteran suicides to better inform VHA's suicide prevention program were often incomplete and inaccurate.

For example, as part of VA's behavioral health autopsy program, which I'll refer to as BHAP, VAMCs collect data on veteran suicides such as date of death, number of mental health visits, and last VA contact. We examined 63 BHAP reports from five VAMCs and found that about two-thirds of them contained inaccurate and incomplete information.

Moreover, this situation is further exacerbated because BHAP reports prepared by VAMCs are generally not reviewed at any level within VHA for accuracy, completeness, or consistency.

Lack of accurate and complete BHAP data limit opportunities to learn from past veteran suicides and ultimately diminish efforts to develop effective methods and approaches to enhance suicide prevention activities and reduce veteran suicides.

VA has made good progress in addressing the six—six recommendations to improve weaknesses we noted in our report. In the six months since our report was issued, one recommendation has been fully implemented and several others are very close to being fully implemented.

More globally, this work illustrates once again a continuing pattern of VHA's noncompliance with its own policies and established procedures, unclear guidance, inaccurate data, and poor oversight. These are among the same factors that led GAO to include VHA on its high-risk list.

Until VA instills a culture throughout the organization that holds its staff and managers truly accountable for effectively performing their responsibilities, appropriately overseeing outcomes, and achieving a recognized standard of excellence, VA—VHA will continue to fall short of performing the highest quality and cost-effective care to our Nation's veterans.

This concludes my opening remarks.

[THE PREPARED STATEMENT OF RANDALL WILLIAMSON APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Williamson, for your remarks.

Dr. Maffucci, did I say that right?

Ms. MAFFUCCI. Yes, you did. Thank you.

Mr. COFFMAN. Thank you.

And you are now recognized for five minutes.

STATEMENT OF JACQUELINE MAFFUCCI

Ms. MAFFUCCI. Chairman Coffman, Ranking Member Kuster, and distinguished members of the subcommittee, on behalf of Iraq and Afghanistan Veterans of America and our nearly 400,000 members and supporters, thank you for the opportunity to share our views and recommendations on prescription management and the potential risk of veteran suicide.

In 2014, IAVA launched its campaign to combat suicide. In February with your help, we celebrated the signing of the Clay Hunt SAV Act into law. This was a first step on a long road to address the challenges of combating suicide among our servicemembers and veterans.

The issue that we're here to talk about today is complex because it encompasses two topics, providing care for veterans seeking relief from chronic pain, mental injuries, and other conditions, and recognizing the potential for misuse and abuse of these powerful drugs. And while these drugs are extremely powerful, they can also be extremely effective for a veteran who has not found relief elsewhere.

A 2011 report estimates that chronic pain affects approximately 100 million American adults and this number is growing. Given the last 14 years of conflict and the very physical daily demands on our troops, we've seen a similar trend among servicemembers and veterans. Over 60 percent the Iraq and Afghanistan veterans seeking VA medical care seek care for musculoskeletal ailments and this is

the most common category for disability compensation. Nearly 60 percent seek care for mental injury.

Within IAVA's own community, two of three respondents to our member survey reported experiencing chronic pain as a result of their service. One in five reported using prescription opioid medications, one in three using anti-anxiety or antidepressant medications.

Among this newest generation of veterans, medical advancements have allowed for higher survival rates from complex injuries, but this also increases the likelihood for lifelong impacts of nerve and skeletal damage. Treatment of pain in these instances can be even more complex because co-occurrence with other conditions like depression, anxiety, PTSD or TBI may limit treatment options.

For clinicians, assessing pain and devising a management strategy can be very difficult as well, particularly given that knowledge in this field is still growing. Primary care physicians who see the bulk of patients with chronic pain report that they feel under-prepared to treat these patients due to lack of training. This includes VHA providers who were surveyed in 2013.

Adding to the challenge are studies showing that untreated pain can actually put an individual at higher risk for suicide and, yet, we also know that prescription medications can result in strong addictions and provide a means for suicide attempts.

The VA reports that over half of all nonfatal suicide events among veterans results from over—overdose or intentional poisoning. This highlights the challenges that clinicians face when treating patients with complex injuries and demonstrates the importance of comprehensive, integrated pain management.

While the VA has moved the needle forward investing in research on pain, publishing an evidence-based clinical practice guideline, implementing an opioid safety initiative, and introducing a stepped case pain management system, more remains to be done.

With approximately 22 veterans dying by suicide every day and more attempting suicide, reducing instances of over-medication and limiting access to powerful prescription medications must be included in a comprehensive approach to addressing this issue.

A recent study showed that while patients receiving opioid therapy are at an increased risk for attempting suicide, following some of the VA's clinical practice guidelines reduced this significantly. This shows the critical need not only for these guidelines, but full implementation of those guidelines.

VA's 2009 directive on pain management which outlines the stepped care approach to pain expired in October of 2014. While it expired in date only and the policy remains active, IAVA is discouraged that updating this important policy has not been prioritized. We urge the VA to prioritize this and—and fully implement it at all VA facilities.

IAVA would also like to emphasize the importance of minimizing the risk of overdose and over-medication through formulary take-back programs and prescription drug monitoring programs.

Last year, an important change to DEA regulation expanded authorization for drug drop-off sites. This change gave VA the ability to stand up drug take-back programs in their hospitals and this is

critical to limiting the possibility of misuse and abuse of powerful—powerful prescription drugs, yet no action has been taken.

And while the VA is working to fully implement its participation in state prescription drug monitoring programs, full implementation remains to be seen and we urge the VA to—to prioritize this as well.

Too often we hear the stories of veterans who are prescribed what seems like an—an assortment of anti-psychotic drugs and/or opioids with very little oversight or follow-up and, yet, we also hear stories of veterans with enormous pain and doctors who won't consider their request for a stronger medication to manage this pain. These are tough challenges and IAVA remains committed to working with the VA and Congress to address them.

Again, thank you for the opportunity to offer our views on this important topic. We look forward to continuing to work with each of you, your staff, and this committee in this critical year ahead. Thank you for your time and attention.

[THE PREPARED STATEMENT OF JACQUELINE MAFFUCCI APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Doctor. I deeply appreciate your testimony.

Thanks to the witnesses.

Dr. Clancy, according to a GAO report, VA deviated from recommended guidelines in most all of the 30 veterans' cases reviewed by not assessing antidepressant treatment properly.

In your opinion, is policy simply ignored or is there just a lack of oversight by leadership?

Dr. CLANCY. So first I want to say that we regard the GAO recommendations, feedback as very important, a gift, if you will, to help us get better. I'm not sure that any guideline written on planet Earth should be followed a hundred percent of the time. Many doctors think of them as tools, not rules, because there will be patients with unique circumstances that don't fit perfectly.

In terms of the follow-up assessment, I think that is important and we need to do a better job. We will be looking to see whether that is a feature of the fact that we had—we're having access problems and it was hard to get people back in or whether we weren't just on the ball. But that is a very important feature.

Mr. COFFMAN. Dr. Clancy, in our case reviews, we found veterans who died of drug toxicity who reported hallucinations and subsequently died by suicide and reported homicidal thoughts.

Are these the improved outcomes you are referring to?

Dr. CLANCY. No, they're not, Mr. Chairman.

Mr. COFFMAN. Dr. Clancy, in response to the GAO report, VA noted that it would conduct chart reviews and develop a plan to determine and address the factors contributing to coding variances. This was to be completed by March 2015.

Has this been completed?

Dr. CLANCY. It is in progress. We are not completed yet. I will also add to that that in addition to that, I have been meeting inspired both by the GAO report and other feedback with Dr. Kudler and a couple of the other national mental health leaders in our system to try to figure out who are the veterans who we think are struggling the most with mental health disorders that we should

be targeting to make sure that they are getting the best possible care.

Mr. COFFMAN. Thank you, Dr. Clancy.

When do you think that report is going to be done?

Dr. CLANCY. I would have to double check on when we committed to having the recommendations done.

Mr. COFFMAN. VA has stated it would examine associations between treatment practices and indicators of recovery or adverse outcomes for veterans being treated with antidepressants. The target date of completion was also March 2015.

Has this been completed?

Dr. CLANCY. I believe that it has. I'd have to double check my notes here. Here we are.

Mr. COFFMAN. Well, can you get a copy of it to the committee?

Dr. CLANCY. Yes, absolutely. We'll submit that.

Mr. COFFMAN. And roughly 63 percent of the behavioral health autopsies reviewed by GAO, critical data was missing.

Is this inaccurate reporting based on incompetence or is it to intentionally keep central office in the dark?

Dr. CLANCY. I have no reason whatsoever to suspect it's to keep central office in the dark. As I understand it, this program was transitioned from doing root cause analyses at individual facilities to a centralized repository about two years ago.

And as you might expect, training reviewers and people who are doing the interviews and collecting the data, to collect that data consistently and accurately took some time and, frankly, some iteration, excuse me, to make sure that we were getting it right.

Dr. Kudler, do you want to add to that?

Dr. KUDLER. Yes. At the time the GAO was—oh, pardon me. At the time the GAO was conducting this study, the behavioral health autopsy program was just being launched. The forms were new. They were in need of refinement. They've been continuously refined as has the training of the suicide prevention coordinators, 300 of them across the country at over 150 facilities who fill them out.

There were questions about, well, what data goes where and how do you count this or where do you go with that. That's now been addressed through training and upgrading of our manuals. We're now reviewing all of these centrally at the national level.

We've also created software that crosswalks these to another suicide prevention tracking system, the SPAN system, so that we can make sure we're accurately looking at these from multiple perspectives.

So the system is continuously improving and it's progressed a great deal since the original report. And we will continue—continue to work on it.

Mr. COFFMAN. Dr. Clancy, this subcommittee has requested the behavioral health autopsies for numerous veterans who have died by suicide and in all cases except one of Kalisha Holmes, VA has stated that this information is confidential, privileged, et cetera, so it cannot be released to us.

If this is true, why was the report for Ms. Holmes released to the committee?

Dr. CLANCY. I would have to take that question for the record. I would say in general, the behavioral health autopsy reports—I

think the Ranking Member Kuster described this more clearly than I could. This is part of quality assurance where you want the most forthright kind of input and observations. And if people think that this is going to be disclosed, we will not get input that is that forthright.

Mr. COFFMAN. Well, I think we are very concerned about the fate of our veterans and this subcommittee and the committee as a whole has an oversight responsibility for your operation. And we can't do that oversight operation and making policy that is best for our veterans if you don't fulfill your obligation and submit that information when requested to the Congress.

Ranking Member Kuster.

Ms. KUSTER. Thank you very much, Mr. Chair.

And thank you to all of our witnesses and particularly Dr. Maffucci.

I really appreciate you being here and sharing with us the recent experience of the veterans returning from, as you mentioned, 14 years of conflict and that the injuries are much more complex. I mean, the good news is people are surviving, but the difficulty is that, as you say, they have chronic lifelong issues.

I want to focus in on how we move forward. I share the concerns that have been expressed about the data and making sure that we are getting at the heart of the issue here. But I am very interested.

As I mentioned, I had a meeting with the team up at White River Junction facility and there is some cutting-edge research, and I will talk to the chair about perhaps bringing in some witnesses to share that, but particularly the opioid safety initiative. And a couple of different things and whichever is the appropriate witness.

One is getting at the heart of what is causing the pain. My husband has chronic pain and many, many years of back pain and various medications and come to find out what he needed was a hip replacement. It wasn't about his back at all. And now he lives pain free with yoga and stretching and exercise and such.

So I would like to find out what is being done to get at the crux of what is causing the pain. Secondly, setting a goal of reducing opioid use and working with practitioners to bring down the opioid use and particularly emphasizing patient education, close monitoring.

They talked about actual drug testing because in our area, selling these opioids on the market, what happens sometimes is people will not use the medication themselves and they can determine that through frequent drug testing which, as you can imagine, is not popular with the patients but necessary, and then alternative medicine, acupuncture. I mentioned yoga, massage, exercise.

So if you could comment on this opioid safety initiative. How far has that gone? How widely has it been—is it in use and what can we do to help move that forward?

Dr. CLANCY. So thank you. Those are all terrific questions. I'm going to start and then turn to Mr. Valentino.

Like the case with depression, we do have a clinical practice guideline that we developed with colleagues from the Department of Defense on the management of chronic pain. That was published in 2010. It will—as of September of this year, it will be updated which is about the frequency you'd want to update these guide-

lines. And we will be having input from veterans and family members.

The guideline does include urine drug testing periodically. And we have, as I mentioned probably too quickly in my opening statement, made in a series of steps that I would—the umbrella of which I would refer to as the opioid safety initiative made data about prescribing patterns at the network level, the facility level, and most recently at the individual clinician level available and visible so that clinicians can actually see what has this patient been on over time, what other drugs are they on and so forth.

Getting to the root of the problem I think is incredibly important. I'd be happy to submit for the record to brief anyone any time about some of the exciting research we have in process because I think it's very important.

I think there's a lot we need to learn in two areas. One is what are the predictors of veterans who or anyone who's likely to use opioids for a short time and go down the path of using them on a regular basis because if we knew then, that's where we would target a lot of efforts.

The second is which veterans are most likely to respond to alternative treatments, to non-narcotic medications and so forth. We—as I said, we have some research going on in that area and have a lot more to learn.

Mike, do you want to add to that?

Mr. VALENTINO. Yes. Thank you.

So this—the opioid safety program is just shy of two years old. And we've had to build it from—from the ground up. And as Dr. Clancy mentioned, it's been very iterative. So initially we focused on this data collection aggregation to identify outlier—potential outlier VISNs. So we focused on those, asked for corrective action plans.

The next iteration was to continue to focus on VISNs, but drill down to VA facilities which we did identify outliers, asked for corrective action plans. We know this is working because 17 medical centers originally identified have now fallen off the list.

We are poised right now at this moment and we—we've built the tools and we're—we're validating them for accuracy to drill down to the individual provider and patient level. This is very complex as you might guess. Someone may show up in data as an outlier, but maybe they're a pain management specialist. Maybe they treat cancer pain. Maybe there are other situations where you would expect this.

So we have to make sure we get it right so there's confidence in the tool, but we've had really, really good results. I'll just name—I'll just go through some of the metrics.

Since we began, we have 110,000 fewer patients receiving any kind of opioid short-term or long-term; 34,000 patients receiving opioids and benzodiazepines together which is a known risk; 75,000 more patients have had a urine drug screen who are long-term opioids, as you mentioned, because that is definitely an opportunity for—diversion and we want to make sure patients are taking it.

We have 92,000 fewer patients on long-term opioid therapy which we define as longer than 90 days. We also have begun to

look at the totality of opioid, the opioid burden. So there are many opioid drugs, but you have to sort of boil those down to a common denominator, morphine equivalent daily doses. And we now have——

Ms. KUSTER. Mr. Valentino, I am sorry. My time is up. I am very interested——

Mr. VALENTINO. Okay.

Ms. KUSTER [continuing]. In what you have to say, but my colleagues need their turn as well. So thank you so much and we can take that on the record.

Mr. COFFMAN. Mr. Lamborn, Colorado.

And let's see if we can not try and run the clock out on some of these answers.

Mr. LAMBORN. Well, I would like to thank the chairman for bringing this important issue to light.

Unfortunately, it comes too late for one of my Colorado Springs families. I would like to tell you the story of Noah, a former marine who served with honor in Iraq in 2009 and Afghanistan in 2011. I won't use his last name, but his parents have offered the use of his picture, so if I could just show you Noah's picture.

After leaving the marine corps, Noah began work on a business degree at the University of Colorado at Colorado Springs and started his own online business based out of Colorado Springs.

Noah comes from a military family, his dad having honorably served for 23 years. Noah chose to put off college so he could serve this great Nation. Unfortunately, his parents are appalled by the care that their son didn't receive from the VA. They believe their son would still be alive had he received better care.

Noah was diagnosed with PTSD and received a 50 percent disability due to PTSD. On April 2nd of this year, he went to the Colorado Springs VA clinic where medical notes from his visit state that he had suicidal thoughts or suicidal ideation specifically. Noah was prescribed a psychotropic drug, Venlafaxine, and sent on his way.

Now, we don't know at this time what this drug did or didn't do, but we know this. He was not referred for suicide prevention. He was not offered counseling and there was no follow-up from the VA. He went missing the evening of May 4th and was found dead from an apparent suicide May 12th of this year, a month ago.

As you can imagine, his family is devastated. They are asking a lot of serious questions, so, Dr. Clancy, I would like to ask you several questions on their behalf.

Why was their son who had been documented with having suicidal thoughts or ideation not referred to suicide prevention? Why wasn't there follow-up from the VA and why wasn't he offered counseling?

Dr. CLANCY. I will look into this personally, Mr. Congressman. That's heartbreaking. I can't even imagine what this—I can imagine, but I know it's horrendous what his family is going through. The picture was worth many, many words as someone who did so much for this country. And I will look into that and get back to you on these and to the family.

Mr. LAMBORN. Would one of the other witnesses have any response to my questions, to the family's questions?

Dr. KUDLER. You know, as a psychiatrist, as somebody who's treated veterans in clinics for 30 years, it's hard to understand the report that we're given and, yet, these seem to be the facts that are available. We have to look into it.

My first thought is that I want to make sure this family has been reached out to directly and that we have a chance to collect this information. As I say, we've created a system. A system can be cold and inhuman, but we need to have a real sit down with them and understand everything that happened from their point of view, questions that they have which may torture them, and we will work with them to do that.

Mr. LAMBORN. Okay. Thank you both.

Mr. Chairman, thank you for having this hearing and I yield back the balance of my time.

Mr. COFFMAN. Mr. O'Rourke, Texas.

Mr. O'ROURKE. Thank you.

Dr. Clancy, a question to which I would like to receive a quick, direct answer. We are touting reduced prescriptions of opioids as though perhaps that in itself is success.

What I would like to know are the consequences. I have veterans that show up to my town hall meetings saying that their prescriptions were cut off without notice, without transition, without ramping down.

How many of those who are no longer receiving prescriptions from the VA are now using heroin or other street drugs?

Dr. CLANCY. We can't know that without—with the information that we have. It is something we worry about constantly. So—

Mr. O'ROURKE. Let me tell you another problem. This is just hopefully helpful feedback for you from El Paso. Others who have prescriptions are required to renew those prescriptions after a monthly visit with their prescriber. They are unable to get the appointment in El Paso to see the prescriber, so they cannot get the prescription renewed. So they go without or they go with something that they shouldn't have that perhaps they buy on the street. And at a minimum, they are suffering. And in some cases, I would connect that suffering to suicides that we see in El Paso.

I would also like to give you the following feedback. As I shared with you when I met with you on Monday, the May 15th access report from the VA shows that El Paso is ranked 157 out of 158 for mental healthcare access. We have 115 mental healthcare positions approved for El Paso. Only 87 of those are filled, leaving a 24 percent vacancy rate.

Your predecessor, when we would relay anecdotal information that I was hearing from veterans, told me we were seeing everybody within 14 days. As you know, we did our own survey and El Paso found that more than one-third of veterans could not get a mental healthcare appointment, not in 14 days, not in a month, just not ever.

That situation, because we are surveying the veterans again right now and we are receiving the responses back, has not improved in the year that we have had new leadership there. This should be for you a five-alarm fire.

I have met with the widows and the mothers of suicides in El Paso far too often and I am continuing to do that. And I just did the last time that I was home in El Paso.

As you know, for whatever reason, the VA has been unable to solve this issue and to treat it as a priority that it should be and to turn around El Paso. I am glad to hear that there are good things happening in other parts of the country, but everything that I do and view is through the prism of the veterans that I serve in El Paso.

You know that we have a proposal from the community in El Paso to address this. I want your commitment that you are going to work with us because the community has come forward in the vacuum of VA leadership and action and will and resources to do the right thing.

I will do whatever it takes to work with you and your team and the secretary to get this implemented, but this is a crisis that has deadly repercussions for the veterans that we all serve in El Paso.

And I want to make sure because we didn't take it seriously over the last year because our statistics and our vacancy and our position relative to mental health access is actually worse than it was a year ago, I want your commitment that you are going to work with me to resolve this, that it is a crisis for you, that it is urgent for you, and that we are going to turn this around.

Dr. CLANCY. You have my full unwavering commitment. We were very impressed with your reaching out and bringing in various members of the El Paso community to work with us. And I want to thank you for your support of our employees during what was a different kind of tragedy at the El Paso facility several months ago, something that cut to the heart of clinicians across the country, but particularly to those serving veterans in El Paso. You have my full commitment.

Mr. O'ROURKE. Thank you.

I yield back.

[Disturbance in hearing room.]

Mr. COFFMAN. All right, sir. I am sorry. You are out of order. You are out of order. Thank you.

Dr. Benishek, Michigan.

Dr. BENISHEK. Thank you, Mr. Chairman.

Well, I want to associate myself with the comments of Mr. O'Rourke for one thing and that is I have seen this as well is that the goal seems to be cutting down the amount of narcotics. And the same circumstances happen in my district, too, where people have just had their prescriptions cut off with no alternative treatment. Figure it out. It has been a real problem.

There are a couple of specifics I want to get to after that and that is something Dr. Kudler said and then something Mr. Williamson said. And Mr. Williamson said there is not that much—there doesn't seem to be that much follow-up on this, the behavioral health autopsy program or we are learning moving forward.

Can you remind me what you said in your testimony, Mr. Williamson, because it seemed like—

Mr. WILLIAMSON. We were talking about—

Dr. BENISHEK [continuing]. You were contradicting what Dr. Kudler said.

Mr. WILLIAMSON. I was talking about oversight. VA conducts very little over the suicide prevention of that program at the local or the national level to see whether data were accurate and complete.

Dr. BENISHEK. Right, right. Now, Dr. Kudler, you said that you are doing oversight and Mr. Williamson said the GAO says you are not. So what is exactly going on?

Dr. KUDLER. The difference is the two years that have passed since this report was written. I'm not questioning the report at all. In fact, I find the report helpful as a real spur to do more.

Dr. BENISHEK. All right.

Dr. KUDLER. At this point, we are making a difference in this. We've developed programs to address—

Dr. BENISHEK. Could you show me the results of the oversight that you have done in the last two years? Could you get that to me, you know, within a reasonable period of time, like a month?

Mr. WILLIAMSON. That's—that's not quite the way it is, I think. I think there is still—to respond to our recommendations on oversight, I don't think VA has completed those yet. It's not the two or three-year lag at all. I think what we're talking about there have been some changes made. There's now a box checked on the—on the behavioral autopsy report that indicates that oversight has been done, but we know that hasn't—

Dr. BENISHEK. That is all there is is a box you are saying, right?

Mr. WILLIAMSON. Well, that's one of the things. And—and they—they are revising guidelines and so on. They are making progress. I'm not going to—but it's not been completed to our understanding.

Dr. BENISHEK. I am not going to give you another chance, Dr. Kudler. Sorry.

But, Dr. Clancy, you said something in your testimony that was very important to me and that is this seems so simple, but the fact is that people who have an idea that they want to hurt themselves have to hang up and dial another 800 number when they are calling into the VA. And you spontaneously said that you are going to have that fixed and be able to just, you know, hit a key and make that work.

So what I want to know is when. Can you give me a date when that all happens that I can call the number and see if it is actually working?

Dr. CLANCY. Absolute—

Dr. BENISHEK. When is that going to happen?

Dr. CLANCY. Absolutely by November or December. One of the things that we have been working very closely with the veterans' crisis line—

Dr. BENISHEK. Great. No.

Dr. CLANCY. We just want to make sure—

Dr. BENISHEK. I don't want you to go on about what happened.

Dr. CLANCY [continuing]. That we don't overstress that system when we do it.

Dr. BENISHEK. I just want to have a date so that if it is not there by November or December—

Dr. CLANCY. Yes.

Dr. BENISHEK [continuing]. Because I completely agree with the guy that stood up here in the back and was out of order in that,

you know, it is just great to keep hearing that you are going to all do work, but from where I sit, you know, the actual accomplishment of the job does not seem to be happening.

So I just——

Dr. CLANCY. No, I hear that.

Dr. BENISHEK [continuing]. I will be back to talk to you in January and hopefully that I have called those places and there actually is a number I can hit because, I mean, I got people calling me all the time.

Dr. CLANCY. I'll be checking before you will.

Dr. BENISHEK. This is ridiculous.

Dr. CLANCY. But, yes.

Dr. BENISHEK. All right. With that, I think I will yield back the remainder of my time. Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Dr. Benishek.

Mr. Walz of Minnesota.

Mr. WALZ. Thank you to the chairman.

And thank you all for being here today.

And I, too, would like to hit on this, the OSI that was implemented in Minneapolis. And we followed this closely since October 2013 and we are getting the results. But I think my colleagues, I would associate with them.

And I know this is nothing new to all of you that we saw a dramatic increase in calls to our office after it was implemented which I think probably is somewhat expected, but I think the lack of maybe being there or the alternative. And I say this very clearly. This issue of mental health parity, mental health treatment certainly is societal-wide.

I am very proud of the work that this committee has started, a small first step on Clay Hunt, but it is going to be the broader issue.

And on the opiate issue, this Nation has vacillated back and forth from over-prescribing to under-prescribing and trying to find this as the research gets it. So I hear that.

I guess my concern and the frustration, and you hear authentic frustration from veterans, whether it be here or all the time, this pain management thing is a tough one, tough, tough, tough. It is tough and I always say this, but I think it is important for context. I represent the Mayo Clinic area, so these are folks dealing with this also on a very big issue.

But I was very proud back in 2008. One of the first bills I was able to move through was the Military Pain Care Act and Veterans Pain Care Act. And out of that came the VHA's pain directive 2009-053. And what it was is we put together through IOM the stepped care pain model which is the old standard, the best practice; is that correct?

Dr. CLANCY. Yes.

Mr. WALZ. Okay. And I won't go through all of it that is here, but what I would say is is that it had a five-year span on it. I wanted to go further, but this is the nature of how we do legislation. It expired in 2014 before it was fully implemented. It did not get reauthorized.

But when we were out in Toma on this issue, Dr. Clancy, you responded, and this was on March 30th, that the VA doesn't need

us to do it, that you can put it in yourself. And I said that is wonderful. Let's do it. And I followed up with a written letter and I don't expect to be a high-maintenance person, but I have heard nothing on my specific question.

So the frustration lies in this was seven years ago, we were dealing with pain management. Seven years ago, we implemented best practices. Seven years ago, the VA started but didn't fully implement it. Eight months ago, it expired. Three months ago, I asked about it.

And I hate the exchanges that we continue to have. I hate the pattern of communication that we now have because it does not bode well for our veterans. It does not fit. In fact, it is very irritating.

So I don't set you up to get up because I wanted to start and preface this that I understand the challenge of this issue. I understand the deep societal issues. I understand the positives we are making and the pluses and minuses. The frustration lies more in that this might not have been the fix, but why didn't we do it? Why aren't we?

Dr. CLANCY. It has been done. It is still being reviewed internally. And I will be honest and say this is an issue that the GAO highlighted in putting us on their high-risk list. And we have got to get better at the process and updating of our policies and directives. But the pain directive has been updated. All policies—

Mr. WALZ. Who knows that?

Dr. CLANCY. Yes?

Mr. WALZ. Who knows that? Would the author of the bill not be someone who would need to know that?

Dr. CLANCY. Well, we're going to tell you as soon as we have reviewed it and made sure that we have gotten consensus and we haven't missed any details. And I apologize. I have not personally seen your letter, but I will make sure that I do see it before the day is over.

Mr. WALZ. Part of this is, and I go back to that, and, again, I don't expect to be high man, you got other priorities to get on here, but this is one of the issues we have struggled with is this very thing. Our job is tasked to do this.

We think we had a pretty good—not us. We built a great coalition from private companies like Boston Scientific to working with your talented people in this. We got a good piece of legislation on it. We are trying to communicate to implement it and we are left in a no man's land where we don't know what to think.

I don't like going out and hammering on you that we haven't heard from it yet, but this is important stuff. And there are some things and I encourage my colleagues to look at this. The things I hear the ranking member asking to put in, she is intuitively clicking into this. That is in the stepped care pain management. The things that you are hearing from Dr. Benishek are in the stepped care. And if we just get it out there, get it implemented, make it best practices, make it SOP, it would be there.

So, again, I encourage you in many cases if you are doing something right, let us know and talk about it, communicate with us, see us as partners in helping our veterans, so the frustration you

hear both here and out in our districts is reduced. So we will look forward to the follow-up.

And I yield back.

Mr. COFFMAN. Thank you, Mr. Walz.

Dr. Roe, Tennessee.

Dr. ROE. Thank you, Mr. Chairman.

And just a couple of things. One on data collection. And certainly when you draw or produce inadequate data, you draw inadequate results. And the results may not be accurate at all. And it is extremely important in healthcare to get the data right because we are going to draw conclusions based on this many patients did this and this many patients did that while the outcome—I mean, I have been involved in those clinical studies for years.

And when you put BS in, you get BS out. And so that is sort of what it looks like has happened right here. And that is being a little crude, but that is absolutely what it looks like you have done.

And Mr. Williamson has pointed out, I mean, you have got half of the BHAP templates were incomplete or inaccurate. You draw bad conclusions from that. You can't help but do it. So I think until you get the data right, you are never going to know. You are going to have one—and, Dr. Clancy, you are right. What works for one patient may not work for another.

And the ranking member certainly has pointed out there are many alternative therapies and what works. And Dr. Murphy whom I am sure you know continually complains about when he is at DoD and has a patient stable and then they are separated from the military and they go to the VA, there is a different formulary there, so they then stop all of what he has taken forever to get the patient stable on and they are now on something else.

So I think that is something that needs to be addressed. He was very adamant about that he sees it a lot since he is still in clinical practice.

And I, too, with Dr. Benishek want to associate myself. I think the outburst that you heard was just frustration from probably a veteran who has either tried to get in or couldn't. And Mr. O'Rourke has every right to be frustrated when he has people lined up outside his office talking about not being able to get in the VA.

And let me share why that is frustrating to me. I have been here six years and change on this committee and we have increased the budget 74 percent. It is not money. It is management. And it is not the amount of money that we are spending on our veterans. There is plenty of money out there to spend. And I don't understand why the system isn't functioning better.

Any comments on that because, Mr. Williamson, I think you pointed out in your testimony poor oversight? Why is that? No accountability. What happens to someone when we find out they are just not following it? Apparently nothing. So I know there are outcomes. You mentioned all of those things.

Mr. Williamson.

Mr. WILLIAMSON. So your question is directed at oversight?

Dr. ROE. Yes, sir.

Mr. WILLIAMSON. Yes. There's a lot of reasons why oversight doesn't happen. And VA does not have the data perform to rigorous oversight.

I don't think there's any willful motive on VA's part. I think it's just that oversight is missing especially at the local level. At that level, accountability is missing; supervisors are not holding employees accountable for doing their jobs correctly.

Dr. ROE. But that seems basic to doing your job to me. I mean, to hold someone accountable for their job, I mean, that is not rocket science. You are not doing your job, so what happens when you don't do your job? Do you lose your job or what happens?

Mr. WILLIAMSON. I'm not sure I'm the right one to answer that, but in an idealistic world, I would think you would lose your job if you are not performing. We should be held accountable for the quality of the work that we do. When we don't do it well, we get feedback. First of all, we should be given expectations, then we get feedback and hopefully corrective action after that. And that's basically business 101—it's common.

Dr. CLANCY. So, Dr. Roe, if I might, I want to say that to you and your colleagues we share your frustration. And I want to salute my colleague, Dr. Kudler, who is working with others to try, yes, so when people who don't do their job should be held accountable if, in fact, we have given them the resources and the capacity to do that job. You can't hold somebody accountable if there are no appointments and no ability to see a patient in follow-up.

Dr. ROE. But Mr. O'Rourke pointed out that there are 20 something people, jobs available right now. We claim we have a job problem.

Dr. CLANCY. Yes.

Dr. ROE. There are 24 people that need a job in El Paso, Texas and there is money there to fund it. So why aren't those positions filled?

Dr. CLANCY. We have tried a lot of varieties of ways to recruit people. Mr. O'Rourke came in with a group of partners from the community. And I think I'm very much looking forward and he has my full commitment to looking at that proposal to see how we can be working—

Dr. ROE. And VA is not making—

Dr. CLANCY [continuing]. With them more effectively.

Dr. ROE [continuing]. It hard for those veterans to leave that system and go to these private practitioners. It is with the veteran's choice card or with a non-VA care because we find that sometimes. It is just so hard with all the rules they have to get, it takes forever for someone to get an appointment.

And one last thing. I know my time is expired. But how long does it take to change a phone number to get—why does it take six months to have some—when you call—and I know how frustrated I get when I call. Punch two for this and three for that. It makes me want to throw my phone away.

How hard is it to do when someone is contemplating suicide to have a phone change to where they go straight to a person, a human being—

Dr. CLANCY. We wanted to make—

Dr. ROE [continuing]. On the other end?

Dr. CLANCY. We want to make sure that we don't overstress the people who are taking the calls, one of whom recently took their own life. As you can imagine, that is a very, very stressful job. So

that's the reason we're just testing it first in about 20 different facilities this summer. And we'll then roll it out full steam this fall.

Dr. ROE. That may be stressful and I am very sorry for that family, but it is very stressful on the other end. That is why they are making the call.

Dr. CLANCY. No, I understand that completely. And we—we want to make sure that when you do hit that one number or whatever the number will be that, in fact, it connects you directly to a counselor because the only thing worse than not having it is doing it then.

And I do have to say that the issue of transitioning servicemembers over to VA, they continue on the drugs that they were getting in the service. We've gone over this with Dr. Woodson at the Defense—

Dr. ROE. I will ask Dr. Murphy today again when I see him on the House floor. He is under a different impression. So I will have him check.

Dr. CLANCY. Well, and I would be happy to follow-up with him as well because if we've missed something in our surveys of veterans, we want to know about that and fix it.

Mr. COFFMAN. Ms. Rice, New York.

Ms. RICE. Thank you, Mr. Chairman.

I mean, I hate to say that maybe the stress for the poor operators comes from the fact that they know that they are not going to have the support from the VA in getting the callers the help that they need.

I would like to take a minute to recognize the work that is being done in my home state in a VISN that covers the Bronx and Manhattan. They specifically reject the prescribe first, diagnose later treatment philosophy that I think is all too often adopted by the VA. They have taken again what shouldn't be a revolutionary approach to pain management, but it is. They actually believe that the first thing you do is diagnose the patient before developing a path of treatment. And instead of prescribing opiates as the default treatment for veterans suffering from pain—and I understand that doctors when a patient comes and presents with real pain, you want to take away the pain. I get that that is the doctor's mode of reaction.

But this facility is using alternative approaches such as acupuncture and exercises to relieve pain. And what we have seen is veterans who undergo these treatments experience a relief from pain without the harmful effects of addictive narcotics. The Bronx VA's outstanding approach to pain treatment should become the norm at all VA facilities nationwide.

My question is to you, Dr. Clancy. What is the VA's version of alternative forms of treatment like meditation, acupuncture, and exercise?

Dr. CLANCY. First of all, let me say I completely share your enthusiasm for what I believe it's VISN 3 is doing.

Ms. RICE. Yes.

Dr. CLANCY. And I have spoken to those folks. It's wonderful. And we have many thousands of veterans actually using alternative forms of therapy. So there is no aversion whatsoever.

For veterans who are already getting opiates like other Americans and some of whom come to us from active duty on those same medications, the path forward is going to be different. It's not starting from day one. So I love what they're doing in New York.

And I have spoken with many veterans and have actually begun to think about how we might use their stories to help those who are struggling to get off opioids and try alternatives. Many of the veterans who take opioids would like not to, but they'd like to kind of wake up and it would all be okay. The journey there is not so easy.

So we actually have to—

Ms. RICE. Because we have a system here that you know works. And I think it was one of my colleagues who told the story about Noah and clearly he was just prescribed drugs. He was not given any follow-up, any alternative, any, you know, therapy, anything like that.

The doctor who is in charge of VISN 3, Dr. Klingbeil, she made a statement that I thought was very accurate. She said that to be on opiates is to be trapped in a cycle of poor function and poor pain control. And that is what we need to get away from.

And I am just imploring you. It is not rocket science. They get it right there. Just export it throughout the rest of the country.

One other thing that I wanted to talk about is a bill that I happen to be a proud cosponsor of that is put forth by our colleague, Ron Kind from Wisconsin. It is H.R. 1628, the Veterans Pain Management Improvement Act, which would establish a pain management board within each VISN to better handle treatment plans for patients with complex clinical pain. They would incorporate doctors, patients, family members into the decision-making process for a veteran's course of treatment.

Has the VHA taken the ideas in this bill under advisement?

Dr. CLANCY. Yes. Representative Kind asked us for our comments and I told him he had my personal full thread of support which may be different than the department's support. But I can't think of anyone who would—I can't think of any reason we would not support that fully.

It was really inspired by that that in updating our clinical practice guideline I wanted to make sure that we had input from veterans and families in doing just that. And I told him that. I think that's—because as heartbreaking as some of the experiences of the veterans are are the experiences of families who raise their hands and said I'm worried about my son, daughter, spouse, whatever, and didn't feel—

Ms. RICE. It is a family issue. It is not even just a serviceperson issue. It is—

Dr. CLANCY. Yes.

Ms. RICE [continuing]. An entire family issue. And I don't think that we want to be a Nation that says to our brave men and women who fight for us—

Dr. CLANCY. I agree.

Ms. RICE [continuing]. And come back so damaged and so injured that we are going to do our best to keep you in a catatonic state for the rest of your life as a pain management therapy. That just cannot be where we come down on this.

So I am begging you to do everything that you can to look at what they are doing in VISN 3 and export it throughout the rest of the country. It is not rocket science.

Thank you very much, Mr. Chairman.

Mr. COFFMAN. Thank you.

I think if I was going to sum up this hearing with the Veterans Health Administration, it would simply be that drugs are a shortcut. They are a shortcut to doing the right thing. They are a shortcut to doing the therapies that are really required to treat our veterans both mentally and physically in terms of management and in terms of those suffering from depressive disorders. And I think that that is disconcerting and it is unfair and hurtful to the men and women who have made tremendous sacrifices for this country in uniform.

And one question that I have is, how many physiologists or rehabilitation physicians does the Veterans Administration have, Dr. Clancy?

Dr. CLANCY. I would have to take that for the record, Mr. Chairman.

Mr. COFFMAN. Well, I've got the number of about 40.

Dr. CLANCY. And I'll get back to you.

Mr. COFFMAN. I've got the number of about 40. So, I mean, therein lies part of the problem. Those are the people central when it comes to pain management and, yet, we are shortchanging that because, again, the easy thing to do is to drug somebody, drug them not to feel pain, drug them to get them up in the morning, drug them so they can go to sleep at night.

And I think when we look at the suicide rates of our veterans, that is reflective of what the Veterans Administration is doing in terms of having drug reliant therapies again as a shortcut for doing the right thing.

Dr. Maffucci—

Dr. Maffucci.

Mr. COFFMAN. Maffucci. Okay. I got it right now?

Dr. MAFFUCCI. Yes.

Mr. COFFMAN. And are you a veteran yourself?

Dr. MAFFUCCI. I am not. I'm a neuroscientist by training and prior to IAVA worked for the Pentagon on behavioral health issues with the Army Suicide Prevention Task Force and other—other programs.

Mr. COFFMAN. Well, I want to thank you for your work on behalf of the men and women who served this country.

What is your view about—I mean, do you believe that, in fact, the over-prescription of drugs is a shortcut?

Dr. MAFFUCCI. I think this is a really complex question to ask because if you look at the history of—of clinician education, medications have always kind of been at the forefront, particularly with pain management.

As a neuroscientist, I can tell you the research is still very young in understanding how pain manifests, how it manifests in individuals. Every individual experiences it differently. And because of that, we also don't have a lot of great treatment options.

However, having said that, there is a lot of research coming out right now that really supports this idea of integrated management

of pain using alternative and complementary medicines. There is—there are some—spinal cord stimulation is a new technology that's out there.

And IAVA actually has a member veteran who was addicted to opioids, was a chronic pain sufferer and was able to get off of those drugs and through spinal cord stimulation and through alternative practices lives a much better life now as a result.

But these are all very new technologies. Doctors don't know about them. They're not using them. And so clinician education is so, so critical to redefining how clinicians look at pain management.

Mr. COFFMAN. Well, I think you would agree, though, that drugs should not be the first course of action? They should be the last course of action?

Dr. MAFFUCCI. Absolutely. I think drugs are—drugs are one option of many and they might be necessary, but they shouldn't be the—the end all be all. They need to be a part of a comprehensive plan.

Mr. COFFMAN. Mr. Williamson, how would you view in terms of the principal modalities or treatment, whether for psychotherapy or for pain management? From what we are seeing here in terms of testimony, it seems to be kind of the first and preferred method of treatment tends to be drug therapy.

Mr. WILLIAMSON. Well, I'm not a clinician and I'm really not qualified to answer that. But GAO will be looking of the opioid program, later this year. So I'll be much more educated after we finish with that study.

Mr. COFFMAN. Well, that is not comforting. We were prepared here to know.

Dr. Kudler, what do you think?

Dr. KUDLER. I'm really glad you asked that question.

Mr. COFFMAN. Yes

Dr. KUDLER. No.

Mr. COFFMAN. Let's—

Dr. KUDLER. No, no. The bottom line—

Mr. COFFMAN [continuing]. Not run the clock here.

Dr. KUDLER. The bottom line is this. Whether it's pain or depression, it takes an integrated approach just as Dr. Maffucci was saying. And different patients need to start in different places. There are patients who will say I can't talk about this. I won't talk about this. And the medication will make that possible in the depression case.

In a pain case, there are people who absolutely need not to go where they mean to go into opiates or come off them, but they believe this is all that would ever work for me. So we need to start where the—where the patient is, where the veteran is and use a mixture.

With my patients, I've always said, look, I have a lot of different tools, talk therapies and medication. This is the good and the bad about each of them. What makes sense to you and, by the way, we can do both. And in most cases, we end up doing both, but often the stepped way.

Mr. COFFMAN. Dr. Clancy, in an OIG report from 2013, it was recommended that VA ensure that facilities take action to improve

post-discharge follow-up for mental health patients, particularly those who are identified as high risk for suicide.

What is being done to ensure that this process is being followed?

Dr. KUDLER. A few years ago, VA put out as a performance measure that veterans must be seen in person or at least by phone in the first seven days after leaving a psychiatric hospital. And this is based on statistics that show this is the most vulnerable time. Actually, the first two weeks, the most vulnerable time for a suicide attempt, especially after treatment of depression or admission for suicide activity.

We've been monitoring this. We are not perfect in this, but we have—we—we are—I—I can't give you the number now. I can provide it later. We are now at a point where all across the Nation, we're tracking this. We have automatic alerts. We have teams that do this work with people. And we've taken it miles further. I wish I could give you the exact number right now. I can provide it.

Mr. COFFMAN. You know what is amazing is from what we are hearing on the ground and from what we are hearing in this committee, it is a world apart. And if for what we are hearing in this committee were true, we wouldn't be here today having this discussion.

Ranking Member Kuster.

Dr. CLANCY. Well, Mr. Chairman, if I might, we're not saying everything is fine and I acknowledged that at the outset. What I did want to tell you is that we are committed to getting it right. This is tough work and we have a lot to improve on. And we very much welcome your support and help.

Mr. COFFMAN. Very hard to get it right if you are not acknowledging the depth of the problem.

Ranking Member Kuster.

Ms. KUSTER. Thank you very much. Thank you, Mr. Chair.

And thank you to our committee, to our panel for coming forward and all the comments from the committee.

I just want to follow-up on where we go from here in terms of sharing best practices. We have now heard Dr. Maffucci. I really appreciate again your commentary and your expertise in this area and to the team from the VA. We have heard about VISN 1. I talked about some examples in White River Junction.

How do these best practices get shared and the research that is underway, how do we move forward with this to make sure that more veterans and their families will be served by this and in particular the clinician education because I think we have got to change some of the parameters and some of the, you know, sort of go-to answers that some of the clinicians have? Where do we go from here with this and how can this committee best stay on top of that and continue to work with the VA to make sure that we are serving these veterans all across the country?

And I will bring El Paso up. Obviously one of the challenges is that this involves a very case management intensive approach. And you are right. The worst case scenario is just to cancel somebody's medication without follow-up because as we all know, that is why people are turning to heroin in the streets.

So how do we get this right and how do we get it right across the board in the VA and what is the follow-up?

Dr. CLANCY. So what I might suggest is that you invite us back for a briefing and we would give you a follow-up. You pick the frequency, a couple of months, three months.

And I did want to—didn't get a chance to say before to Congressman O'Rourke that I do have people monitoring for this abrupt discontinuation of medications. And I'm really worried about it when people change providers, right? If we're sending out a message that says we want to see fewer veterans on opioids, it's much, much easier when someone changes providers to just say no. That is absolutely not acceptable and that is no definition of success here. So I wanted to be very, very clear on this point.

Some of these challenges are areas where U.S. medicine is struggling in general. Chronic pain in particular and for mental health, we've had to blaze some trails. There is no clear-cut blood test that one can do like a blood sugar or blood pressure, whatever, to double check on the diagnosis or assessment.

It depends a lot on the use of standardized questions in some cases. And this we are working very hard on right now. We are changing how we schedule appointments and simplifying it so that it is much easier to get veterans in for that follow-up assessment.

But you should hold us accountable and I would look forward to showing you where we've been and where we're going. In no way do I not want to say that we have problems to solve. We do. We own them and we're stepping up to them and look forward to your support.

Where you can help is helping to work with us on reducing stigma. I mean, this remains a huge, huge problem. And also, I think sending a sense that you are supporting the efforts to get better care for clinicians—I mean, for veterans.

One of our challenges is that a lot of young people are not choosing to go into these fields and that is the ultimate recruitment problem is that if they're not—we have terrific incentives thanks to the Clay Hunt Act, in terms of debt reduction thanks to the Veterans Choice Act and so forth. And those are great tools, but someone has to actually make the decision to go down that path.

Ms. KUSTER. Thank you very much.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

And, Dr. Clancy, I want to stress again the need for you to turn over documents when requested by Congress. And your failure to do so makes our job very difficult.

Mr. O'Rourke, Texas.

Mr. O'ROURKE. And, Dr. Clancy, thank you for addressing the El Paso issue and the larger issue within the VA to ensure that you are monitoring those veterans who are going to be coming off of opiates. But, again, the feedback stands because I am hearing it directly from veterans that that is apparently not happening in El Paso.

And I think we both must conclude that for every veteran who takes the time to come down to a town hall meeting despite whatever they are going through to tell their congressman that they are having this problem in front of 200 other veterans and is admitting that they are receiving opiates and now are doing without that there are many others that that person represents who have just given up and says why should I bother.

So we have got a problem in El Paso, perhaps nationally in terms of ramping people down or finding an alternate therapy to pair with their cessation of opiates.

I would like you to respond to something that we have heard the secretary say and read about in the press that he has got 28,000 positions to fill in the VHA. It is something that Under Secretary Sloan Gibson reiterated three weeks ago, four weeks ago in a hearing here.

And then when the ranking member and I and some other Members of Congress and the Senate were in your command and control center on the 8th Floor a few weeks back, we heard that that number was actually not 28,000. It was 50,000 positions to be filled at the VHA.

Could you confirm that number and could you tell me how you are prioritizing those hires? And obviously I am getting to if we have a crisis in mental health and we are treating all hires the same, we have a problem. If you are prioritizing mental health, here is a chance to tell this committee and the public at large.

Dr. CLANCY. So I did not hear the number 50,000, so I'm going to have to check on that and get back to you directly I think would probably be the easiest way to say that. With 300,000 employees sorting out normal turnover which is somewhere around seven or eight percent across all the disciplines from, you know, what we're—areas where we're trying to fill is a little bit challenging.

We have identified five areas that are the highest priority, physicians, nurses, mental health professionals, physician assistants, and I'm blocking on the fifth one, but mental health professionals is clearly on that list. And, in fact, we have been way ahead of the curve compared to the rest of the country in terms of hiring mental health professionals from multiple disciplines. They work as teams. We've got them in primary care as well as working in mental health clinics and so forth.

Trying to do everything to make it almost impossible to seek assistance and get it. If you actually do get care from one of our facilities, we have a long way to go. I was simply commenting on the overall pipeline problem.

The other area where we are beginning—where we do a lot now but I think could do much more is in tele-mental health. So Big Spring, Texas which isn't that far from you in Texas terms, you know, they tried very, very hard to recruit psychiatrists and had a problem and recently recruited one from Wisconsin who is not moving. It—that individual is providing all virtual care.

So we're working with them to try to figure out how to make that business process work as smoothly as possible. Many veterans prefer that. They find it a bit less confrontational.

Mr. O'ROURKE. And I appreciate that. And as I yield my time, I will just conclude. You have asked for an additional briefing or hearing to follow-up. I hope that when you come back, you come back with a plan for El Paso or any under-served community. And you say you know what, we are paying psychiatrists and psychologists and therapists and social workers and counselors X. I am going to pay them X plus 20 percent to get them to El Paso or that under-served community and then to retain them once they are there because you have a huge problem with retention as well, and

that is a suggestion, or some other plan that really treats this as the crisis that it is versus the, you know, we are making this a priority. We are going to do this, that, and the other.

I need dollars on the table, specific offers, deals that will get that psychiatrist or mental health professional there in the first place and then keep them there after. So I hope to hear specifics next time.

So appreciate your answers to our questions today.

And, Mr. Chair and Ranking Member, thank you for holding this hearing. Really important. Thanks.

Mr. COFFMAN. Ranking Member Kuster.

Ms. KUSTER. Thank you, Mr. Chair.

And just briefly I want to follow-up for my colleague that we will do a follow-up hearing and not only on the types of pain management and techniques that do seem to be working but in particular, I would like to include tele-mental health. And maybe we could even do a short demonstration, but just for you that that might be an alternative in this crisis situation that you have. I want to make sure that we stay on top of this so that our colleague, his region gets served.

Thank you.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

Our thanks to the witnesses. You are now excused.

Today we have had a chance to hear about problems that exist within the Department of Veterans Affairs with regard to prescription management and veteran suicides. This hearing was necessary to accomplish a number of items, to demonstrate the lack of care and follow-up for veterans prescribed medications for mental disorders, to demonstrate the inaccuracies and discrepancies in the data collected by VA regarding veteran suicides and those diagnosed with mental disorders and, three, to allow VA to inform this subcommittee what it plans to do to improve these glaring deficiencies in order to ensure veterans are receiving the care they deserve.

I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous materials. Without objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining in today's conversation.

With that, this hearing is adjourned.

[Whereupon, at 12:12 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF
DR. CAROLYN CLANCY
INTERIM UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

JUNE 10, 2015

Good morning, Chairman Coffman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss the provision of mental health care to Veterans, particularly those who are at risk for suicide. I am accompanied today by Dr. Harold Kudler, Acting Chief Consultant for Mental Health Services and Mr. Michael Valentino, Chief Consultant of Pharmacy Benefits Management Services. My written statement will discuss VA's many initiatives enhancing the appropriate use of prescription medications as well as VA programs caring for individuals who experience mental and substance use disorders, including programs for suicide prevention.

Opioid Safety Initiative

Chronic pain, which is a major health problem for Servicemembers and Veterans, is also a national public health problem as outlined in the 2011 study by the Institute of Medicine (IOM). At least 100 million Americans suffer from some form of chronic pain. The IOM study describes in detail many concerns about pain management, including system-wide deficits in the training of our Nation's health care professionals in pain management and the problems caused by a fragmented health care system. The over-use and misuse of opioids for pain management in the United States are a consequence of a health care system that continues to struggle with these challenges. About 30% of the U.S. adult population experiences chronic pain, a large number to manage. The problem of chronic pain in the VA is even more daunting with 50% to 60% of Veteran patients experiencing chronic pain due to battle field and other service

related injuries. It is important to note that nationally, most patient deaths from overdose are unintended. Many Veterans have also incurred head injuries, collectively referred to as traumatic brain injuries (TBI), which can compound psychological injuries such as post-traumatic stress disorder resulting from their experiences. The combination of pain, a head injury and mental health disorder can further degrade quality of life for Veterans and their families, increasing the risk for overdose, substance abuse, and suicide.

The VA health care system has identified and broadly responded to the many challenges of pain management through policies supporting clinical monitoring, education and training of health professionals and teams, and expansion of clinical resources and programs. The Opioid Safety Initiative (OSI) was implemented system-wide in August 2013 and is producing the desired results. The goal of the OSI is to make the totality of opioid use visible at all levels in the organization. The OSI includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average morphine equivalent daily dose (MEDD) of opioids. Results of key clinical metrics measured by the OSI from Quarter 4 Fiscal Year 2012 (beginning in July 2012) to Quarter 2 Fiscal Year (FY) 2015 (ending in March 2015) are:

- 109,862 fewer patients receiving opioids
- 33,871 fewer patients receiving opioids and benzodiazepines together
- 74,995 more patients on opioids that have had a urine drug screen to help guide treatment decisions
- 91,760 fewer patients on long-term opioid therapy
- The overall dosage of opioids is decreasing in the VA system as 12,278 fewer patients are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing.

- o The desired results of the Opioid Safety Initiative have been achieved during a time that VA has seen an overall growth of 90,488 patients that have utilized VA outpatient pharmacy services.

Special Medication Concerns

Psychotropic Drug Safety Initiative

In an effort to ensure our Veterans receive safe, effective and evidence-based psychopharmacologic treatments, the VHA launched the Psychotropic Drug Safety Initiative (PDSI) in December of 2013. The PDSI is a VHA nation-wide quality improvement initiative coordinated through the Office of Mental Health Operations (OMHO) in collaboration with Mental Health Services (MHS) and Pharmacy Benefits Management (PBM). Every VAMC in the country has been required to participate through local or VISN-wide quality improvement initiatives. The PDSI aims to address possible overprescribing, possible problems in clinical management, misalignment between prescribing and diagnosis, and meeting specific mental health needs through pharmacotherapy. The key aspects of this program include developing measures and sharing data with VISNs and facilities, providing feedback and support for local quality improvement action planning, supporting a collaborative community of practice, and disseminating information about psychotropic prescribing.

The PDSI program utilizes a dashboard that contains indicators of prescribing practices intended to facilitate quality improvement by helping providers prioritize patients to review. The PDSI program also conducts twice monthly QI collaborative conference calls. Even though this program has only been operational for just over a year, it has already demonstrated a positive impact. As of the end of quarter 1 of FY2015, we have seen significant improvement in the national score of 14 of the 20 PDSI measures. For example, the proportion of Veterans with alcohol use disorder who received pharmacotherapy treatment rose over 1% nationally, which means 5,902 additional Veterans received these evidence-based treatments. Similarly, the proportion of Veterans with opiate use disorder who received opiate agonist therapy increased nearly 2% nationally, with an additional 2,420 Veterans receiving these evidence-based

treatments. We have also noted a 2% decrease nationally in the proportion of Veterans with PTSD receiving benzodiazepines and a 1% decrease in the proportion of Veterans with PTSD and no psychosis diagnosis who received an antipsychotic medication.

Academic Detailing Initiative

On March 27th 2015, I mandated national implementation of an Academic Detailing Initiative in every network by June 30th, 2015. Based on the results of a 3-year pilot, I believe Academic Detailing holds the promise of continued progress personalizing Veterans' pain management and assure medication safety in our most vulnerable Veterans with Mental Health concerns. This program was designed to allow specially trained clinical pharmacists to assess individual providers' prescribing practices and meet with them one-on-one over a period of time to identify any treatment gaps. The goal of these meetings is to aligning individual prescribing practices with published medical evidence where gaps exist. Clinical pharmacists from 16 of the 21 networks are engaged in training for academic detailing interventions; 130 clinical pharmacists have already completed the required training for delivering the behavior change interventions with prescribers. Thus far, 1534 interventions of academic detailers have been recorded. The topics covered in these interventions include pain and opioid use in 872 interventions, 389 for Opioid Overdose Education and Naloxone Distribution and 174 for benzodiazepine safety.

Overdose Education and Naloxone Distribution (OEND)

VHA has also undertaken a national initiative to make overdose education and naloxone rescue kits available to patients at risk of accidental or intentional overdose. Naloxone can reverse an opioid overdose, preventing overdose death and morbidity when administered in a timely manner. Distribution of overdose rescue training and naloxone kits is a novel intervention within health care settings, and it is being rapidly adopted by VA. To date, 822 VHA providers have begun prescribing these kits to at risk patients, with over 4250 patients receiving training and kits. Already, Veterans have

reported reversing 70 opioid overdoses with the naloxone VHA prescribed, representing potential lives saved from these efforts.

VHA has developed a predictive model and clinical decision-support tool to identify patients with opioid prescriptions at risk of suicide-related events and overdose. This tool is being pilot tested and optimized with pain and mental health specialists.

VHA has continued efforts to ensure that effective substance use disorder treatments are available for patients with substance use disorders, knowing that they have an elevated risk for suicide and overdose. Greater engagement in VHA substance use disorder programs is associated with lower suicide attempt risk and reduced criminal behavior in Veterans initiating substance use disorder treatment. VHA continues to increase availability of specialty substance use treatment, increasing the number of patients treated per year with specialty treatment services and with opioid agonist treatment for opioid use disorders.

National Take-Back Initiative

In September 2014, the Drug Enforcement Administration (DEA) published a final rule for the Secure and Responsible Drug Disposal Act of 2010 in the Federal Register, effective October 9, 2014. This Rule provides three voluntary methods for ultimate users (e.g. Veterans) to dispose of their unwanted/unneeded medications in a secure and responsible manner: 1- Mail Back Packages, 2- On-site Collection Receptacles, and 3- Take Back Events.

VA has been aggressively planning and implementing drug disposal options for Veterans. A Directive, which is currently in concurrence, will require VA medical centers to implement at least one practical, accessible, and secure disposal method, when appropriate and in compliance with DEA regulations. In April 2015, Mail Back Envelopes were provided to all VA facilities for distribution to Veterans. Guidance on envelope distribution to maximize Veteran engagement and use was also provided and as of May 31st, 2015, 369 envelopes, which contained approximately 160 pounds of unwanted/unneeded medication, have been returned to a vendor for environmentally responsible destruction.

VA is also piloting the use of on-site collection receptacles in 6 VA medical centers. The pilot involves pharmacy and Security & Law Enforcement staff with different sites of care including ambulatory care, community living centers and residential treatment programs. Data will be gathered on Veteran usage, feedback, safety, costs, and resource utilization to evaluate decisions going forward. Thus far, both Veterans and staff report a high level of satisfaction with this service and approximately 800 pounds of unwanted/unneeded medication have been collected and destroyed. Removal of this medication from Veterans' homes reduces the risk of diversion as well as intentional and unintentional overdoses and poisonings.

Mental Health Overview

Since September 11, 2001, more than two million Servicemembers have deployed to Iraq or Afghanistan. Long deployments and intense combat conditions require comprehensive support for the emotional and mental health of Veterans and their families. Accordingly, VA continues to develop and expand its mental health and substance use disorder programs as an integrated system of care. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from 927,052 in Fiscal Year (FY) 2006 to more than 1.5 million in FY 2014. We anticipate that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA believes this increase is partly attributable to proactive screening to identify Veterans who may have symptoms of depression, post-traumatic stress disorder (PTSD), substance use disorder, or those who have experienced military sexual trauma. In addition, VA has partnered with the Department of Defense (DoD) to develop the VA/DoD Integrated Mental Health Strategy to advance a coordinated public health model to improve access, quality, effectiveness, and efficiency of mental health services for Servicemembers, National Guard and Reserve, Veterans, and their families.

VA has many entry points for VHA mental health care. These entry points include medical centers, Community Based Outpatient Clinics (CBOCs), Vet Centers providing readjustment counseling, a Veterans Crisis Line, VA staff on college and

university campuses, and other outreach efforts. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increases in staff toward mental health services.

VA has expanded access to mental health services with longer clinic hours, telemental health capability to deliver services, and standards that mandate immediate access to mental health services to Veterans in crisis. In an effort to increase access to mental health care and reduce any stigma associated with seeking such care, VA has integrated mental health into primary care settings. From the beginning of FY 2008 through March 2015, VA has provided more than 4.7 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 1,137,000 unique patients. This improves access by bringing care closer to where the Veteran can most easily receive these services, and improves quality of care by increasing the coordination of all aspects of care, both physical and mental. In addition, a second round of VA Community Mental Health Summits has recently been completed at virtually all major VA facilities across the nation and analysis of feedback from VA and Community participants is underway. Based on 2013 Summit recommendations, Community Mental Health Points of Contact have been identified at every VA Medical Center. The Community MH POC provides ready access to information about VA eligibility and available clinical services, ensures warm handoffs at critical points of transition between systems of care, and provides ongoing liaison between VA and Community Partners. At each of the 2014 Summits, featured presentations included best practices in support of military and Veteran families in populating the National Resource Directory to enhance referrals to VA and community resources across America for use by any Servicemembers, Veterans, family members, referring clinicians or other stakeholders.

VA has made deployment of evidence-based therapies a critical element of its approach to mental health care and offers a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for the full range of mental health problems, including Post-Traumatic Stress Disorder (PTSD), substance use disorders, and suicidality. While VA is primarily focused on

evidence-based treatments, we are also assessing complementary and alternative treatment methodologies that need further research, such as meditation and acupuncture in the care of PTSD. For example, a recently published clinical trial suggests that mindfulness techniques were as effective in treating depression as antidepressants. VA has trained over 6,100 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD, Cognitive Processing Therapy and Prolonged Exposure Therapy, as indicated in the VA/DoD Clinical Practice Guideline for PTSD¹. VA operates the National Center for PTSD, which guides a national PTSD mentoring program, working with every specialty PTSD program across the VA health care system. The Center has begun a PTSD consultation program for any VA practitioners (including primary care practitioners and Homeless Program coordinators) who request consultation regarding a Veteran in treatment with PTSD. So far, the consultation program has provided over 2,600 consultations and triaged an additional 165 requests from the Suicide Risk Management Consultation Program. Starting in January 2015, the PTSD Consultation program has expanded so that providers outside of VA can now consult with the program as well as VA providers.

Specialized mental health centers of excellence (CoE) are another essential component of VA's response to meeting the mental health needs of Veterans. These centers, including 10 Mental Illness Research, Education and Clinical Centers (MIRECC), the National Center for PTSD and four additional centers strive to improve the health and well-being of Veterans through world-class, cutting-edge science, education and clinical care. The centers are designed to be incubators for new investigators, new clinicians, new treatments, new ways of educating staff and patients, and new ways of delivering care.

We know that there have been issues with Veteran access to care. We take those concerns seriously and continue to work to address them. In addition, receiving direct feedback from Veterans concerning their care is vitally important. During Quarter

¹ http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

4 of FY 2013, as part of VHA's effort to seek direct input from Veterans in understanding their perceptions regarding access to care, we conducted a survey of over 40,000 Veterans who were receiving mental health care. The replication of that survey for FY2015 is currently underway and approximately 50,000 Veterans who have received mental health services will be surveyed by the end of July 2015 about their perceptions of mental health services. These results, and other outreach to Veterans, aid us as we strive to improve the timeliness of appointments; reminders for appointments; accessibility, engagement, and responsiveness of clinicians; availability and agreement with clinician on desired treatment frequency; helpfulness of mental health treatment; and treatment with respect and dignity.

Programs and Resources for Suicide Prevention

Overall, Veterans are at higher risk for suicide than the general U.S. population, notably Veterans with PTSD, pain, sleep disorders, depression, and substance use disorders. VA recognizes that even one Veteran suicide is too many. We are committed to ensuring the safety of our Veterans, especially when they are in crisis. Our suicide prevention program is based on enhancing Veterans' access to high-quality mental health care and programs specifically designed to help prevent Veteran suicide.

In 2011, the age-adjusted rate of suicide in the U.S. general population was 12.32 per 100,000 persons per year. At just over 12 for every 100,000 U.S. residents, the 2011 rate of suicide has increased by approximately 15 percent since 2001. Rates of suicide in the United States are higher among males, middle-aged adults, residents in rural areas, and those with mental health conditions.

The most recent available data show that suicide rates are generally lower among Veterans who use VHA services than among Veterans who do not use VHA services. In 2011, the rate of suicide among those who use VHA services was 35.5 per 100,000 persons per year; a decrease of approximately 6 percent since 2001. Rates of suicide among those who use VHA services have remained relatively stable; ranging from 35.5 to 37.5 per 100,000 persons per year over the past 4 years. Despite evidence of increased risk among middle-aged adults (35-64 years) in the U.S. general

population, rates of suicide among middle-aged adults who use VHA services have decreased by more than 16 percent between the years 1999-2010. Decreases in suicide rates and improvements in outcomes were also observed for some other high-risk groups. Between 2001 and 2010, rates of suicide decreased by more than 28 percent among VHA users with a mental health or substance abuse diagnosis, and the proportion of VHA users who die from suicide within 12 months of a survived suicide attempt has decreased by approximately 45 percent during the same time period. Available data suggest suicide risk is not evenly distributed across all Veteran groups. More than 70% of all Veteran suicides occur among adults aged 50 years and older. Recent analyses of VA data (2000-2010) also identified significant increases in rates of suicide among male Veterans between the ages of 18 and 29 years and there is evidence of increased risk for suicide among female Veterans of all ages when compared to females in the U.S. general population.

The Veterans Crisis Line/Military Crisis Line

In partnership with the Substance Abuse and Mental Health Services Administration's National Suicide Prevention Lifeline, the Veterans Crisis Line/Military Crisis Line (VCL/MCL) connects Veterans and Servicemembers in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline (1-800-273-TALK (8255), then press 1) that offers 24/7 emergency assistance. August 2014 marked seven years since the establishment of the initial program, which was later rebranded to show its direct support for Servicemembers. It has expanded to include a chat service and texting option. As of the end of March 2015, the VCL/MCL has rescued 48,000 actively suicidal Veterans. As of March 2015, VCL/MCL has received over 1,746,000 calls, over 217,000 chat connections, and over 35,000 texts; it has also made over 282,000 referrals to Suicide Prevention Coordinators. Based on the 2012 Presidential Executive Order, we expanded the capacity of the Veterans Crisis Line by 50 percent.

Suicide Prevention Coordinators

VA has a network of over 300 Suicide Prevention Coordinators (SPC) located at every VA medical center and the largest CBOCs throughout the country. Overall, SPCs facilitate implementation of suicide prevention strategies within their respective medical centers and clinics to help ensure that all appropriate measures are being taken to prevent suicide in the Veteran patient population, particularly Veterans identified as being at high risk for suicidal behavior, and the SPCs engage in outreach to other Veterans, family members, and community partners.

SPCs are responsible for implementing VA's *Operation S.A.V.E* (Signs of suicidal thinking, Ask the questions, Verify the experience with the Veteran, and Expedite or Escort to Help). This is a one-to-two hour in-person training program provided by VA SPCs to Veterans and those who serve Veterans to help prevent suicide. Suicide prevention training is provided for every new VHA employee during Employee Orientation. Our goal is to increase mental health awareness wherever Veterans and their family members are present and to continuously enhance and expand our response to their needs.

SPCs participate in outreach activities, meetings with state and local suicide prevention groups with Active Duty/National Guard and Reserve units as well as college campuses. Each SPC is required to complete five or more outreach activities in his or her local community each month. To ensure that high-risk Veterans are being monitored appropriately, SPCs manage a Category I Patient Record Flag (PRF) with a corresponding High-Risk List. The primary purpose of the High Risk for Suicide PRF is to communicate, consistent with appropriate privacy protections, to VA staff that a Veteran is at high risk for suicide, and the presence of a flag should be considered when making treatment decisions. SPCs ensure that all Veterans identified as high risk for suicide have completed a safety plan that is documented in their medical record, and that the Veteran is provided a copy of his or her safety plan.

The Joint Suicide Data Repository

In 2010, DoD and VA launched a Joint Suicide Data Repository (SDR) as a shared resource for improving our understanding of patterns and characteristics of suicide among Veterans and Servicemembers. The combined DoD and VA search of data available in the National Death Index represents the single largest mortality search of a population with a history of military service on record. The DoD/VA Joint SDR is overseen by the Defense Suicide Prevention Office and VA's Suicide Prevention Program.

On February 1, 2013, VA released a report on Veteran suicides including data from the SDR, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. With assistance from state partners providing real-time data for SDR, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations that need targeted interventions. This new information will assist VA in identifying where at-risk Veterans may be located and improving the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. These data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations (e.g., rural areas), as well as care settings, such as primary care, in order to replicate effective programs in other areas. VA continues to receive state data that is being included in the SDR. VA plans to update the suicide data report later this year.

VA's National Efforts

Suicide prevention efforts must extend to reach Veterans who may not seek assistance. Therefore, VA has focused on increased targeted outreach efforts throughout the country to Veterans and their family members with significant emphasis on safety. We encourage Veterans and their families to learn more about mental illness and to take precautions particularly during times of stress.

VA has sponsored public service announcements, rebranded and optimized the VCL/MCL Web site for mobile access and viewing, and developed social and traditional

media advertisements designed to inform Veterans and their families of VA's VCL/MCL resources. During National Suicide Prevention Month in September 2014, VA launched its new outreach campaign theme for this year, "The Power of 1," which emphasizes that just one person, one conversation, or one small act can make a big difference to a Veteran or Servicemember in crisis.

Furthermore, VA is engaged in ongoing research to determine the most effective mental health treatments and suicide prevention strategies. VA has also established the Mental Health Innovations Integrated Project Team that is working to implement early intervention strategies for specific high-risk groups. Through early intervention, VA hopes to reduce the risk of suicide for Veterans in these high-risk groups.

Another national suicide prevention initiative is VA's Behavioral Health Autopsy Program (BHAP). BHAP is designed to enhance suicide prevention efforts by systematically collecting information for all deaths by suicide reported to VHA clinicians and Suicide Prevention Coordinators. BHAP is a multiphase quality improvement initiative that consists of standardized chart reviews for all Veterans' suicides known to VHA staff and interviews with bereaved family members. Medical chart reviews of suicide decedents offer important clinical information concerning Veterans' VHA service utilization.

In addition, VA established an online Community Provider Toolkit for individuals outside of VA who provide care to Veterans. This provides an important resource in the wake of the Veterans Access, Choice, and Accountability Act of 2014. This Web site features key tools to support the mental health services provided to Veterans including information on connecting with VA, understanding military culture and experience, and working with patients with a variety of mental health conditions.

Readjustment Counseling Service

VA's Readjustment Counseling Service (RCS) provides a wide range of readjustment counseling services to eligible Veterans and active duty Servicemembers who have served in combat zones and their families. RCS also provides comprehensive readjustment counseling for eligible Veterans and Servicemembers who

experienced military sexual trauma, as well as offering bereavement counseling to immediate family members of Servicemembers who died while on active duty. These services are provided in a safe and confidential environment through a national network of 300 community-based Vet Centers located in all 50 states (as well as the District of Columbia, American Samoa, Guam, and Puerto Rico), Mobile Vet Centers, and the Vet Center Combat Call Center (877-WAR-VETS or 877-927-8387). In FY 2013, Vet Centers provided over 1.5 million visits to Veterans, active duty Servicemembers, and their families. The Vet Center program has provided services to over 30 percent of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Veterans who have left active duty. As the President announced in August 2014, the First Lady and Second Lady's Joining Forces initiative is promoting awareness of Vet Centers for combat Veterans, Servicemembers, and their families.

Research

VHA is engaged in multiple research projects related to mental health, suicide and violence, as well as optimizing pharmacological and non-pharmacological interventions for pain and psychiatric conditions. Several current studies are addressing opioid use, including:

- An ongoing study, titled "Impact of Interventions to Reduce Violence and Substance Abuse among VA Patients" that focuses on the use of new intervention approaches targeting the use of violence prevention skills and means of sustaining substance use remission.
- A recently funded study focused on Justice-involved Veterans (i.e. those detained by or under the supervision of the criminal justice system) that aims to improve utilization of VHA mental health/ substance abuse disorder (SUD) care.
- An ongoing study seeking to provide guidance on indications for opioid reassessment in primary care.
- An ongoing study examining a program called "Comprehensive Opioid Management in Patient Aligned Care Teams" that uses a web-enabled

electronic, interactive voice response telephone monitoring and care management system to facilitate patient engagement, conduct regular opioid monitoring and provide relevant education.

- An ongoing study examining opioid prescribing in VHA before and after the Opioid Safety Initiative.

In addition, the Pain Workgroup of the SUD, Quality Enhancement Research Initiative (QUERI) is working to increase utilization of non-pharmacological, evidence-based pain management in specialty SUD treatment settings, and to improve the understanding and measurement of opioid misuse in SUD specialty care.

Closing Statement

Mr. Chairman, VA is committed to providing timely, high quality care that our Veterans have earned and deserve, and we continue to take every available action and create new opportunities to improve suicide prevention services.

United States Government Accountability Office



Testimony

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VA HEALTH CARE

Improvements Needed to the Monitoring of Antidepressant Use for Major Depressive Disorder and the Accuracy of Suicide Data

Statement of Randall B. Williamson
Director, Health Care

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee:

I am pleased to be here to discuss our recent work on the monitoring of veterans with major depressive disorder (MDD) who were prescribed an antidepressant and data collection efforts by the Department of Veterans Affairs (VA) on veteran suicides. In 2013, VA estimated that about 1.5 million veterans required mental health services, including for MDD. MDD is a particularly debilitating mental illness and is associated with reduced quality of life, reduced productivity, and increased risk for suicide.¹ These negative effects underscore the importance for veterans of timely, evidence-based assessment for and treatment of MDD, which may include medications such as antidepressants, psychotherapy, or a combination of both. Based on our previous analysis of VA data from veterans' medical records and administrative sources, 532,222 veterans had a diagnosis of MDD from fiscal years 2009 through 2013, and among those veterans, about 499,000 (94 percent) veterans were prescribed at least one antidepressant by a VA provider.² According to VA, the prevalence of MDD among veterans being treated in VA primary care settings is higher than that among the general population.

In addition to providing ongoing care to veterans with MDD, VA plays a role in suicide risk assessment and prevention among veterans. According to VA in a June 2013 report, about one-quarter of the 18 to 22 veterans who die by suicide each day were receiving care through

¹MDD is characterized by the presence of depressed mood or loss of interest or pleasure along with other symptoms for a period of at least 2 weeks that represent a change in previous functioning. These symptoms include significant weight loss; insomnia or excessive sleeping; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; and recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, Va: American Psychiatric Association, 2013).

²Veterans were classified as having a diagnosis of MDD if, in at least one fiscal year included in our review, they had two or more outpatient encounters or at least one inpatient hospital stay with a diagnosis of MDD. The 532,222 veterans diagnosed with MDD represent about 10 percent of veterans who received health care services through VA. This estimate is based on published Congressional Research Service data on the number of veterans who received health care services through VA from fiscal years 2009 through 2013 (roughly 5.5 million).

VA.³ Research has identified numerous risk factors for suicide among veterans, which include substance use disorder, physical impairments, previous suicide attempts, and depression. Additionally, life stressors, such as marital or financial problems, contribute to a veteran's risk of suicide.

Given the debilitating effects that depression can have on veterans' quality of life, VA's monitoring of veterans with MDD is critical to ensuring that they receive care that is associated with positive health care outcomes. Additionally, the relatively high veteran suicide rate makes it important that VA use data that it collects related to veteran suicides to drive its prevention efforts. Today I will address two areas: the extent to which (1) veterans with MDD who are prescribed an antidepressant receive recommended care, and (2) VA medical centers (VAMC) are collecting information on veteran suicides as required by VA.

My statement is based on a GAO report released in November 2014 examining VA's monitoring of veterans with MDD who have been prescribed an antidepressant and the use of suicide data within VA.⁴ For our work examining the care received by veterans with MDD who are prescribed an antidepressant, we reviewed VA policy documents and interviewed VA Central Office officials responsible for developing and implementing VA mental health policy. We also conducted site visits to six VAMCs, which we selected for variation in complexity of health care services offered, geographic location, and number of veterans using mental health services.⁵ We reviewed a random, nongeneralizable sample of medical records for 5 veterans treated at each of the 6 VAMCs—for a total of 30 veterans—to assess the extent to which the antidepressant treatment-related care VAMCs provided was consistent with three evidence-based treatment recommendations included in VA

³VA/Department of Defense (DOD) Assessment and Management of Risk for Suicide Working Group, *VA/DOD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide* (June 2013).

⁴GAO, *VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data*, GAO-15-55 (Washington, D.C.: Nov. 12, 2014).

⁵These six VAMCs were located in Canandaigua, New York; Gainesville, Florida; Iowa City, Iowa; Philadelphia, Pennsylvania; Phoenix, Arizona; and Reno, Nevada. In contrast to the other site visits, which were completed in person, we completed the site visits to the VAMCs located in Gainesville, Florida, and Reno, Nevada, through telephone interviews.

guidelines.⁶ Results from our medical record review cannot be generalized to the VAMC or across VAMCs. For our work examining the data that VA requires VAMCs to collect on veteran suicides, we reviewed VA policies, guidance, and documents related to VA's suicide prevention efforts to identify the data collected by VA staff on veteran suicides. We also interviewed VA Central Office and VAMC officials responsible for VA's suicide prevention program, obtained documents and interviewed officials regarding the collection of veteran suicide data, and compared data obtained from VAMCs to information included in the veterans' medical records and information we obtained from VA Central Office.⁷ Results from our review of veteran suicide data can be generalized to the VAMCs we visited, but cannot be generalized to other VAMCs. In May 2015, in preparation for this statement, we met with VA officials to discuss the status of VA's implementation of action plans to address the six recommendations included in our November 2014 report.

The work on which this statement is based was conducted, with updates in May 2015, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Further details on our scope and methodology are included in our report.

Background

VA provides care to veterans with mental health needs in VAMC primary and specialty care clinics. The *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook (Handbook), which defines VA's minimum clinical requirements for mental health services, requires that VA facilities provide evidence-based treatment through the administration

⁶The 30 veterans we selected were diagnosed with MDD and had a new treatment episode of an antidepressant in calendar year 2012. For our review we selected three evidence-based treatment recommendations for inclusion in our review that had among the highest strength of research evidence, were sufficiently specific to enable us to determine the extent to which VA providers were following the recommendation, and would not require clinical judgment to determine the extent to which VA providers were following the recommendation.

⁷We reviewed completed information on veteran suicides from five of the VAMCs included in our review. One VAMC reported having no veteran suicides as of the date of our site visit; therefore, our analysis of suicide data does not include this VAMC.

of medication, when indicated, consistent with the MDD clinical practice guideline (CPG) recommendations.⁸ The CPG is guidance intended by VA to reduce current practice variation between clinicians and provide facilities with a structured framework to help improve patient outcomes, but should not take the place of the clinician's clinical judgment. The MDD CPG includes approximately 200 evidence-based recommendations to provide information and assist in decision making for clinicians who provide care for adults with MDD. CPG recommendations describe, for example, the use of standardized assessments of veterans' depressive symptoms as part of an evidence-based treatment plan.⁹

In June 2006, VA began implementing several initiatives aimed at suicide prevention, including appointing a National Suicide Prevention Coordinator, developing data collection systems to increase understanding of suicide among veterans and inform VA suicide prevention programs, and instituting suicide prevention programs in all VAMCs.¹⁰ VA Central Office uses several mechanisms to collect data on veteran suicides to help improve its suicide prevention efforts, including the Behavioral Health Autopsy Program (BHAP).¹¹ The BHAP initiative, which began in December 2012, is a quality improvement initiative

⁸The MDD CPG is formally known as the *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder* (May 2009). The MDD CPG was issued by the joint VA/DOD Evidence-Based Practice Work Group in 2009. Formed in 1999 and composed of VA and DOD officials, the VA/DOD Evidence-Based Practice Work Group makes decisions about which CPGs for specific conditions will be developed and oversees their development.

⁹According to the MDD CPG, veterans with MDD treated with antidepressants should be closely observed, particularly at the beginning of treatment and following dosage changes, to maximize veterans' recovery and to mitigate any negative treatment effects, including worsening of depressive symptoms.

¹⁰The Handbook requires VAMCs to have a suicide prevention coordinator whose responsibilities include establishing and maintaining a list of veterans assessed to be at high risk for suicide; monitoring these veterans; responding to referrals from staff and the Veterans Crisis Line; and collecting and reporting information on veterans who die by suicide and who attempt suicide.

¹¹VA also collects data through the following mechanisms: Suicide Prevention Application Network, in which VAMCs submit information on the number of veterans that completed suicides, the number of suicide attempts, and indicators of suicide prevention efforts; suicide behavior reports, which clinicians must complete when they learn that a veteran attempted or completed suicide and add to the veteran's medical record; and root cause analyses that are completed by VAMC patient safety managers for suicide attempts and completed suicides under certain circumstances.

intended to improve VA's suicide prevention efforts by identifying demographic, clinical, and other related information on veteran suicides that VA Central Office can use to develop policy and procedures to help prevent future veteran deaths.¹² VA Central Office officials explained that the BHAP initiative allows them to collect more systematic and comprehensive information about suicides, including information gleaned from interviews of family members of those veterans who die by suicide. VA Central Office has provided suicide prevention coordinators with a BHAP guide on how to complete the fields in the BHAP template.

**Veterans in Our
Review Often Did Not
Receive
Recommended Care,
and VA Lacks
Methods to Track
Whether
Recommended Care
Is Provided**

Our recent work, based on the three CPG recommendations we selected, has found almost all of the 30 veterans with MDD in our review who had been prescribed antidepressants received care that deviated from the MDD CPG recommendations. For example, we found that although the CPG recommends that veterans' depressive symptoms be assessed at 4-6 weeks after initiation of antidepressant treatment using a standard assessment tool to determine the efficacy of the treatment, 26 of the 30 veterans were not assessed using such a tool within this time frame. Additionally, 10 veterans did not receive follow up within the time frame recommended in the CPG. Table 1 below depicts the specific recommendations we reviewed and the number of veterans that did not receive care consistent with the corresponding CPG recommendation.

¹²Veteran suicide data for the BHAP initiative are submitted by VAMCs to VA's Center of Excellence for Suicide Prevention. The Center of Excellence was created by VA Central Office, and for the purposes of our testimony, we refer to the Center of Excellence as part of VA Central Office.

Table 1: Number of Veterans in GAO's Sample Not Receiving Care As Recommended in the Clinical Practice Guideline (CPG) for Major Depressive Disorder (MDD)

| CPG recommendation | Number of veterans not receiving care as recommended in the CPG for MDD |
|--|--|
| To enhance antidepressant treatment, veterans should be educated on when to take the medication, possible side effects, risks, and the expected duration of treatment, among other things | 6 of 30 veterans lacked documentation of patient education when the medication was prescribed |
| Standardized assessments of depressive symptoms, such as the Patient Health Questionnaire-9, should be used to monitor treatment at 4-6 weeks after initiation of treatment and after each change in treatment | 26 of 30 veterans were not assessed using a standardized assessment tool at 4-6 weeks after initiation of treatment 18 of 30 veterans were not assessed using a standardized assessment tool at any encounter ^a 10 of 30 veterans did not have a follow-up encounter that occurred 4-6 weeks after initiation of treatment ^b |
| A plan should be developed that addresses the duration of antidepressant treatment, among other things | 1 veteran of 30 did not have a planned date for follow up and plan for future care documented in the veteran's medical record at the initial encounter |

Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-15-648T

Note: We included 30 veterans in our review. Our review began with the encounter during which a VA clinician ordered an antidepressant to treat depressive symptoms (initial encounter) and five follow-up encounters with a VA clinician, or sooner if the veteran did not have five follow-up encounters. Our review was limited to encounters during which the antidepressant treatment was reviewed, including encounters during which side effects and treatment effect were assessed, but no change was made to medication orders.

^aOf the 30 veterans included in our review, only 6 were assessed using a standardized assessment at the initial encounter where antidepressant medication was prescribed. VA Central Office officials explained that they would expect a standardized assessment to be conducted at the start of an antidepressant to establish a baseline score.

^bThree veterans did not receive a follow-up encounter at all. Two veterans did not show for scheduled appointments that were within the CPG recommended time frame. Five veterans did not have a follow-up encounter until after 6 weeks.

We also found that VA does not always know the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG, and some clinicians at VAMCs we visited described instances in which they generally do not follow the CPG recommendations. For example, officials from two VAMCs we visited explained that they do not routinely use the nine item Patient

Health Questionnaire (PHQ-9).¹³ According to officials at one of these VAMCs, the standard of care is to conduct a clinical interview and observation. However, the CPG recommendation states that the PHQ-9 combined with a clinical interview should be used to obtain the necessary information about symptoms and symptom severity. It also states that the PHQ-9 improves diagnostic accuracy and aids treatment decisions by quantifying symptom severity. Additionally, we found that VA Central Office has not developed a mechanism to determine the extent to which mental health care delivery in VAMCs conforms to the recommendations in the MDD CPG. While deviations from recommended practice may be appropriate in many cases due to clinician discretion, VA has not fully assessed whether these examples are acceptable deviations from the CPG. VA Central Office and some VAMCs have implemented limited methods to determine the extent to which veterans are receiving care that is consistent with some of the CPG recommendations.¹⁴ However, without a system-wide process in place to identify and fully assess whether the care provided is consistent with the CPG, VA does not know the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG and whether appropriate actions are taken by VAMCs to mitigate potentially significant risks to veterans. The CPG is intended to reduce practice variation and help improve patient outcomes, but without an understanding of the extent to which veterans are receiving care that is consistent with the CPG, we concluded that VA may be unable to ensure that it meets the intent of the CPG and improves veteran health outcomes.

To ensure that veterans are receiving care in accordance with the MDD CPG, we recommended that VA implement processes to review data on veterans with MDD who were prescribed antidepressants to evaluate the level of risk of any deviations from recommended care and remedy those that could impede veterans' recovery. VA concurred with our

¹³The PHQ-9 is a diagnostic tool, which uses the nine MDD diagnosis symptoms as criteria to help clinicians make a criteria-based diagnosis of depressive disorders and measure depression severity to aid treatment decisions.

¹⁴These methods include (1) a psychopharmacology quality improvement initiative that began in fiscal year 2014 consisting of a series of prescribing practice metrics such as the proportion of veterans with depression prescribed three or more concurrent antidepressant medications for 60 or more continuous days, and (2) a software system called the Behavioral Health Laboratory that some VAMCs have implemented to help ensure that veterans with MDD who are prescribed antidepressants receive care consistent with the CPG when the veteran is treated in a primary care clinic.

recommendations and stated that VA would examine associations between treatment practices and indicators of veteran recovery or adverse outcomes. VA Central Office officials reviewed whether a cohort of veterans with MDD received treatment with an antidepressant that was in line with MDD CPG recommendations.¹⁵ However, in choosing CPG recommendations to review, VA officials told us that they chose the recommendations for review based on the ease of obtaining the needed data and because the antidepressant medication coverage measure is nationally recognized, rather than based on a methodical review of all of the CPG recommendations to identify those that may put veterans at risk and could impede veterans' recovery if not followed, as we recommended in our November 2014 report. Therefore, it is not clear whether the CPG recommendations that VA chose to review were among those that may put veterans at risk and could impede recovery if not followed. Moreover, VA has not indicated whether it has implemented a process that will review CPG recommendations on an ongoing basis to identify deviations that place veterans at risk and impede recovery. This recommendation remains open pending further VA action.

Diagnostic coding discrepancies further complicate VA's ability to know if veterans with MDD are receiving care consistent with the CPG. Specifically, we found that for 11 of the 30 veterans' medical records we reviewed the clinician coded the encounter as "depression not otherwise specified," a less specific code than MDD, even though the clinician documented a diagnosis of MDD in the veteran's medical record. Therefore, VA's data may not fully reflect the extent to which veterans have MDD due to a lack of diagnostic coding precision by clinicians, or the extent to which such discrepancies may permeate VA data.¹⁶ As a result, VA's ability to monitor veterans with MDD and assess its performance in treating veterans as recommended in the MDD CPG and measuring health outcomes for veterans is further limited because VA may not be fully aware of the population of veterans with MDD.

¹⁵To do this, VA reviewed (1) the extent to which veterans received antidepressant medication coverage for at least 84 days during a 12-week period; (2) rates of psychiatric hospitalization; and (3) the association between the receipt of guideline-consistent care and changes in depression symptoms documented using PHQ-9 scores.

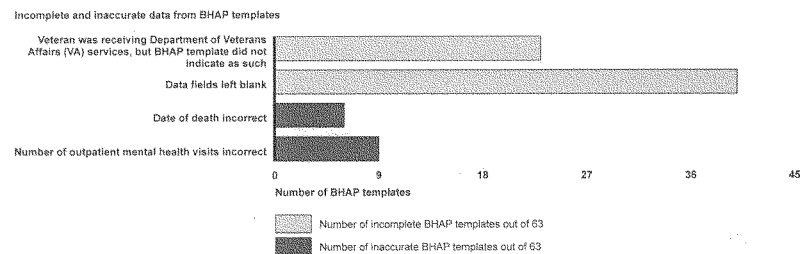
¹⁶VA's data on the number of veterans with MDD are based on the diagnostic codes associated with patient encounters.

To address this shortcoming, our report recommended that VA (1) identify the extent to which there is imprecise diagnostic coding of MDD by examining encounters with a diagnostic code of "depression not otherwise specified" and (2) determine and address the factor(s) contributing to imprecise coding. VA concurred with our recommendations and stated that they would examine patterns of diagnostic coding among veterans with new episodes of depression by evaluating diagnosis patterns and treatment settings, as well as conduct chart reviews for a sample of veterans to examine the diagnosis in the veteran's medical record and the diagnostic code used for the encounter. VA's review of the accuracy of diagnostic codes is ongoing. Additionally, during the course of our review, VA Central Office officials reported that they had discovered a software mapping error in VA's medical record system where selection of MDD as a diagnosis when using a keyword search function may mistakenly result in the selection of the "depression not otherwise specified" diagnostic code. While this error has been resolved, according to VA officials the solution would only apply to encounters going forward and would not retroactively correct any previous coding discrepancies. As a result, any such instances would still be coded in VA's system as "depression not otherwise specified," even though these veterans were diagnosed with MDD, and therefore data VA collected prior to resolving the software error may still not fully reflect the number of veterans with MDD.

**Data VA Collects on
Veteran Suicides
Were Not Always
Complete, Accurate,
or Consistent**

Our recent work has found that demographic, clinical, and other data submitted to VA Central Office on veteran suicides were not always completely or correctly entered into the BHAP Post-Mortem Chart Analysis templates (BHAP templates)—a mechanism by which VA Central Office collects veteran suicide data from VAMCs' review of veterans' medical records. We found that over half of the 63 BHAP templates we examined had incomplete or inaccurate information (see fig. 1).

Figure 1: Number of Behavioral Health Autopsy Program (BHAP) Post-Mortem Chart Analysis Templates with Incomplete or Inaccurate Data



Source: GAO analysis of VA data. | GAO-15-548T

It is important that VA have complete, accurate, and consistent data because VA Central Office uses this information to compile internal reports as part of VA's quality improvement efforts for its suicide prevention program, and unreliable data limits VA Central Office's ability to develop policy and procedures aimed at preventing veteran deaths.¹⁷ VA Central Office used veteran enrollment information when compiling the BHAP report in March 2014. Specifically, VA Central Office included clinical data in the BHAP report only for veterans utilizing VA services. However, we found that clinical data for 23 of the 63 BHAP templates we reviewed would not be included in the report because of missing data, such as not indicating whether the veteran was enrolled in VA health care services, even though the veteran had a VA medical record.

Additionally, 40 of the 63 BHAP templates we reviewed included various data fields where no response was provided, resulting in incomplete data. For example, for 19 templates, VAMC staff did not enter requested data as to whether the veteran had all or some of 15 active psychiatric symptoms within 12 months prior to the veteran's date of death. These missing fields are counted as "no" in the report, meaning that the veteran

¹⁷Department of Veterans Affairs, *Behavioral Health Autopsy Program Interim Summary, December 1, 2012 – February 27, 2014* (Mar. 13, 2014). This report includes information on veterans who die by suicide, both with and without a history of VA health care service utilization.

did not have these symptoms. For at least one BHAP template we reviewed, the nonresponse for the question about the psychiatric symptom of isolation would have counted as "no" in the report; however, officials from the responsible VAMC told us that the veteran did have this symptom. Furthermore, we found that VAMCs did not always submit BHAP templates for all veteran suicides known to the facility, as required by the BHAP guide, and VA Central Office does not have a process in place to determine whether it is receiving the BHAP templates for all known veteran suicides. For example, one VAMC had completed 13 BHAP templates at the time of our site visit but had not submitted them; however, neither the VAMC nor VA Central Office were aware that these templates had not been submitted until after we requested them from VA Central Office.

We also found numerous instances of inaccurate data in the 63 BHAP templates we reviewed. For example, we found 6 BHAP templates that included a date of death that was incorrect based on information in the veteran's medical record. The difference in the dates of death in the veterans' medical records and the dates of death in the BHAP templates ranged from 1 day to 1 year. The accuracy of the date of death recorded in the BHAP template is important because it is used as a point of reference to calculate other fields, such as the number of mental health visits in the last 30 days. Without accurate information, VA cannot use this information to determine whether policies or procedures need to be changed to ensure that veterans at high risk for suicide are being seen more frequently by a mental health provider to help prevent suicides in the future.

We also found several situations where VAMCs interpreted and applied instructions for completing the BHAP templates differently, resulting in inconsistent data being reported across VAMCs. For example, one VAMC included a visit to an immunization clinic as the veteran's final visit, while another VAMC did not include this type of visit, even though this was the last time the veteran was seen in person. The BHAP guide indicates that the final visit should be the last time the veteran had in-person contact with any VAMC staff, but the BHAP guide does not identify the different types of visits that should be counted. Additionally, VA policy and guidance states that the BHAP template should be completed for all suicides known to the facility, but at the five VAMCs we visited, these data were not always being reported. VA policy and instructions do not explicitly state that veterans not being seen by VA also should be included, and in the absence of this declaration, some VAMCs interpreted the instructions to mean that only veterans being seen by VA should be

included in the data submitted. Therefore, two VAMCs have submitted data only for veterans being treated by VA, while the others include data on all known veteran suicides—whether they have been treated by VA or not. When VAMCs do not provide consistent data, VA Central Office will receive and use inconsistent data in preparing its trend reports, such as BHAP reports, which are intended to be used to improve suicide prevention efforts.

Further, we found that VA did not have an established process for reviewing the accuracy of BHAP templates, and for the sites we covered in our review, BHAP templates were not being reviewed by VA officials at any level for accuracy, completeness, and consistency. Therefore, our findings at five VAMCs could be symptomatic of a nationwide problem, and other VAMCs may also be submitting incomplete, inaccurate, or inconsistent suicide-related information and VA may not be getting the data it needs across the department to make appropriate resource decisions and develop new policy. We also found that VA lacks sufficient controls, such as automated data checks, to ensure the quality of the existing BHAP data. Not reviewing the data is inconsistent with internal control standards for the federal government, which state that agencies should have controls over information processes, including procedures and standards to ensure the completeness and accuracy of processed data.¹⁸

To improve VA's efforts to inform its suicide prevention activities, we made three recommendations in our November 2014 report that directed VA to (1) clarify guidance on how to complete the BHAP templates to ensure that VAMCs are submitting consistent data on veteran suicides, (2) ensure that VAMCs have a process in place to review data on veteran suicides for completeness, accuracy, and consistency before the data are submitted to VA Central Office, and (3) implement processes to review data on veteran suicides submitted by VAMCs for accuracy and completeness. VA agreed with our recommendations and, to date, has made some progress in addressing these recommendations.

¹⁸See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

-
- VA has issued clarifying guidance to suicide prevention coordinators and VA officials reported that suicide prevention coordinators expressed being more comfortable with filling out the BHAP templates. We closed the first recommendation as implemented.
 - The last two recommendations remain unimplemented pending VA's completion of planned actions.
 - To ensure that the BHAP data are accurate, complete, and consistent, VA created a checkbox in the BHAP template to indicate that the data were checked by VAMC leadership. VA's initial random checks indicate the checkbox is being used and VAMC leadership is reviewing entries resulting in better consistency of the data. VA plans to run monthly reviews to determine compliance.
 - Additionally, VA created a software program to compare data from the BHAP templates to the data entered into another suicide prevention database maintained by VA. VA officials plan for this review to become part of the quarterly routine review process and information about missing cases will be sent back to the VAMCs for correction on a quarterly basis.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you might have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Randall B. Williamson, Director, Health Care at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Marcia A. Mann, Assistant Director; Emily Binek; Cathleen Hamann; Sarah Resavy; and Jennifer Whitworth.

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Statement of Jacqueline A. Maffucci, Ph.D.¹
Research Director, Iraq and Afghanistan Veterans Of America
before the
House Veterans' Affairs Committee
Subcommittee on Oversight and Investigations
for the hearing titled:
Prescription Management and the Risk of Veteran Suicide
June 10, 2015

Chairman Coffman, Ranking Member Brown, and Distinguished Members of the Subcommittee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our nearly 400,000 members and supporters, I would like to extend our gratitude for the opportunity to share our views and recommendations regarding prescription management and the potential risk of veteran suicide. In 2014 IAVA launched its Campaign to Combat Suicide. In February of this year, with your help we celebrated the signing of the Clay Hunt SAV Act into law. This was a first step on a long road to address the challenges of combating suicide among our service members and veterans. The issue that we have been invited to talk about today is a complex one because it encompasses two topics: providing care for veterans who are seeking relief from chronic pain and other conditions, and recognizing that there is potential for misuse of these powerful drugs intended to provide relief. And while these drugs are extremely powerful, they can also be extremely effective for a veteran who has not found relief elsewhere.

According to a 2011 Institute of Medicine report², chronic pain affects approximately 100 million American adults and this number is growing. Given the last 14 years of conflict and the very physical daily demands on our troops, we've seen a similar trend among service members and veterans. Over 60 percent of the OEF/OIF veterans seeking VA

¹ Dr. Jacqueline Maffucci, IAVA's Research Director, holds a Ph.D. in neuroscience from The University of Texas at Austin. She previously worked with Army staff and senior leaders to develop, implement, and monitor research programs and opportunities to address the health and wellness needs of service members.

² Institute of Medicine. (July 2011). Relieving Pain in America.

medical care seek care for musculoskeletal ailments³ and this is the most common category for disability compensation. Within IAVA's own community, two out of three respondents to our member survey reported experiencing chronic pain as a result of their service. Additionally, one in five were using prescribed opioid medications.

Among this newest generation of veterans, medical advancements have allowed for higher survival rates from complex injuries, but this also increases the likelihood for lifelong impacts of nerve and skeletal damage. Treatment of pain in these instances can be even more complex, because co-occurrence with other conditions, such as depression, anxiety, PTSD, or TBI may limit treatment options for the veteran.

For clinicians, assessing pain and devising a management strategy can be very difficult as well, particularly given that this is a relatively new area of focus in the clinical research field. Related to this, the primary care physicians, who see the bulk of patients with chronic pain, have repeatedly reported that they feel underprepared to treat these patients due to a lack of training. In a 2013 study specific to VHA, this was echoed by the VHA providers surveyed⁴.

Adding to the challenge are studies showing that untreated pain can actually put an individual at higher risk for suicide⁵, and yet we also know that prescription medications can provide a means for suicide attempts, with over half of all non-fatal suicide events among veterans resulting from overdose or intentional poisoning⁶. This highlights the challenges that clinicians face every day when treating patients with complex injuries that might include physical and psychological ailments. It also demonstrates the importance of comprehensive, integrated pain management for military and veteran medical care.

The VA and DoD have both invested in moving the needle forward in this area, investing in research on pain and pain management, publishing an evidence-based Clinical Practice Guideline, implementing an opioid safety initiative, and introducing a stepped-case management system where primary care physicians have the support of an integrated, multi-disciplinary team of providers to design and implement a comprehensive treatment plan for the patient.

However, there is certainly room for improvement. With approximately 22 veterans dying by suicide every day, and more attempting suicide⁷, reducing instances of overmedication and limiting access to powerful prescription medications that can be used to intentionally overdose must be included in a comprehensive approach to

³ Department of Veterans Affairs. (June 2015). VA Health Care Utilization Among OEF/OIF/OND Veterans Cumulative from 1st Qtr FY 2002-1st Qtr FY 2015

⁴Lincoln LE et al. (2013) Barriers and Facilitators to Chronic Non-Cancer Pain Management in Primary Care. *J. Palliative Care & Medicine*.

⁵ Ilgen MA et al. (2013). Noncancer pain conditions and risk of suicide. *JAMA Psychiatry*.

⁶Kemp J. and Bossarte R. (2012). Suicide Data Report 2012. Department of Veterans Affairs.

⁷Ibid.

addressing the issue. A recent study showed that while patients receiving opioid therapy are at an increased risk for attempting suicide, following some of the critical care guidelines recommended in the VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain reduced this risk significantly⁸.

This shows the critical need not only for policies and guidelines, but full implementation of those guidelines. VA's 2009 Directive on Pain Management, which outlines the stepped care approach to pain management, expired in October 2014. While IAVA understands that it expired in date only and the policy remains active, we are also extremely discouraged that the update to this important policy has not been prioritized and the new policy is still pending. We urge the VA to prioritize this to insure that the guidance provided by this important policy is not lost. Once reinstated, the challenge remains to uniformly and effectively implement this guidance at all VA facilities.

IAVA also would like to emphasize the importance of minimizing the risk of overdose and over-medication through the creation of formulary take-back programs and the use of state prescription monitoring programs within the VA.

Last year, a change to DEA regulation expanded the authorization for drug drop-off sites to pharmacies, hospitals, clinics and other authorized collectors. This important change in law gave VA and DoD the ability to stand up formulary take back programs in their hospitals. This is a critical mechanism for means control, removing unused prescriptions from the general populations to limit the possibility of misuse and abuse, and yet, no action has been made to move this forward.

While the VA is working to fully implement its participation in state prescription drug monitoring programs, IAVA urges the VA to move faster. Full implementation is critical to increase visibility across VA and non-VA clinicians so that they can be more informed as they work with their patients to provide safe and effective care.

Too often we hear the stories of veterans who are prescribed what seems like an assortment of anti-psychotic drugs and/or opioids with very little oversight or follow-up. On the flip side, there are also stories of veterans with enormous pain and doctors who won't consider their requests for stronger medication to manage the pain. These are tough challenges and IAVA remains committed to working with the VA and Congress to address them.

Again, we appreciate the opportunity to offer our views on this important topic, and we look forward to continuing to work with each of you, your staff, and this Committee to improve the lives of veterans and their families.

Thank you for your time and attention.

⁸ Im JJ et al. (2015). Association of Care Practices with Suicide Attempts in US Veterans Prescribed Opioid Medications for Chronic Pain Management. *J Gen Intern Med*.

Dr. Jackie Maffucci Short Bio

As Research Director, Jackie closely tracks the latest information and emerging trends in the veteran's space, developing a range of informational reports to bring attention to veteran's issues across sectors and inform our policy positions and priorities. Jackie holds a Bachelor of Science from Cornell University and a Doctorate of Philosophy in Neuroscience from The University of Texas at Austin. Prior to her position at IAVA, Jackie spent nearly four years as a consultant for the Pentagon focusing on behavioral health policy for the Army. This included over two years spent on the Army Suicide Prevention Task Force. Among other responsibilities, she acted as the liaison to the Department of Defense research community working to translate research into policy. Additionally, she was Editor in Chief for The Journal of Washington Academy of Sciences from 2010-2013.

Statement on Receipt of Grants or Contract Funds

Neither Ms. Maffucci nor the organization she represents, Iraq and Afghanistan Veterans of America, has received federal grant or contract funds relevant to the subject matter of this testimony during the current or past two fiscal years.

STATEMENT FOR THE RECORD OF
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
PRESCRIPTION MISMANAGEMENT AND THE RISK OF VETERANS SUICIDE

JUNE 10, 2015

By the time Justin Minyard discovered the video of himself stoned, drooling and unable to help his daughter unwrap her Christmas presents, he was taking enough OxyContin®, oxycodone and Valium every day to deaden the pain of several terminally ill cancer patients.

"Heroin addicts call it the nod," the former Special Forces soldier says of his demeanor in that video. "My head went back. My eyes rolled back in my head.

I started drooling on myself. My daughter was asking why I wasn't helping her, why I wasn't listening to her."

*Seeing that video jolted Minyard out of a two-year opiate stupor. He asked a Fort Bragg pain specialist to help him get off the painkillers his primary care physician had prescribed. "I was extremely disappointed in myself," he says. "I knew I couldn't do that to my family again."*¹

A study published in the Journal of American Medicine in 2012 noted veterans of Iraq and Afghanistan with mental health diagnoses, mostly post traumatic stress disorder (PTSD), are significantly more likely to receive prescriptions for oxycodone, hydrocodone, and other opioids than those with symptoms of pain and no mental health issues. The study notes, these powerful drugs had the worst outcomes with patients with mental health diagnoses, such as addictions, overdoses, and other risk use patterns. Veterans from these wars suffering from pain and PTSD-prescribed opioids may be at a higher risk for misuse.²

Chairman Coffman, Ranking Member Kuster, and distinguished Members of the committee, on behalf of National Commander Michael D. Helm and the more than 2 million members of The American Legion, we thank you and your colleagues for the work you do in support of service members, veterans and their families.

The American Legion and veterans at large are frustrated when we hear stories about veterans who are slipping through the cracks of the system. For example, when we hear about veterans with a history of substance abuse and suicidal thoughts being left alone in a waiting room inside

¹ 1 Excerpt "On the Edge" The American Legion Magazine story by Ken Olsen, April 1, 2014

² JAMA: Association of Mental health Disorders with Prescription Opioids and High-Risk Opioid Use in US Veterans of Iraq and Afghanistan, March 7, 2012

a VA Medical Center, or where a veteran was able to obtain drugs from a hospital visitor and later died from an overdose, is unconscionable and unacceptable³.

What We're Doing to Help:

The American Legion has long been concerned with the unprecedented numbers of transitioning veterans who are suffering from post traumatic stress disorder (PTSD) and traumatic brain injury (TBI) which are commonly known as the “signature wounds” of the war on terror. These veterans are also returning home with other complex injuries such as burns, visual impairments, spinal cord injuries, amputations, and musculoskeletal injuries resulting in them living in chronic pain on a daily basis. In addition to the numerous injuries and illnesses that plague returning servicemembers they are also faced with the daunting task of navigating their way through a transition process that can be fragmented and confusing.

To address these ongoing problems, The American Legion created a TBI and PTSD Committee in 2010 to investigate the existing science, medical procedures, and alternative treatments being offered to servicemembers and veterans who are suffering with TBI and PTSD within the Departments of Defense (DOD) and Veterans Affairs (VA) healthcare systems.⁴

In July 2010, The American Legion testified in front of this committee at a hearing entitled *Examining the Progress of Suicide Prevention Outreach Efforts at the U.S. Department of Veterans Affairs*. In our testimony, The American Legion made the following seven recommendations to improve suicide and mental health efforts for the Departments of Veterans Affairs (VA) and Defense (DOD).⁵ These recommendations still stand today.

- Congress should exercise oversight on VA and DOD programs to ensure maximum efficiency and compliance.
- Congress should appropriate additional funding for mental health research and to standardize DOD and VA screening, diagnosis and treatment protocols.
- DOD and VA should expedite development of a Virtual Lifetime Medical Record for a single interoperable medical record to better track and flag veterans with mental health illnesses.
- Congress should allocate separate Mental Health funding for VA's Recruitment and Retention incentives for behavioral health specialists.
- DOD should establish a Suicide Prevention Coordinator at each military installation and encourage DOD and VA to share best practices in research, screening and treatment protocols between agencies.
- Congress should provide additional funding for Telehealth and virtual behavior health programs and providers and ensure access to these services are available on VA's web pages for MyHealthyVet, Mental Health and Suicide Prevention as well as new technologies such as Skype, Apple I-Phone Applications, Facebook and Twitter.

³ *Modern Healthcare: Deaths at Atlanta VA Hospital Prompt Scrutiny*

⁴ Resolution 25: TBI and PTSD Ad Hoc Committee: October 2010

⁵ HVAC: Subcommittee on Oversight and Investigation Hearing-July 14, 2010

- *DOD and VA should develop joint online suicide prevention service member and veteran training courses/modules on family, budget, pre, during and post deployment, financial, TBI, PTSD, Depression information.*

In September 2013, The American Legion launched a **Suicide Prevention Web Center** on its national website to provide veterans and their families with life-saving resources and programs during their time of transition and need. The American Legion's online Suicide Prevention Web Center builds on several suicide-prevention initiatives launched in recent years by the Department of Defense (DOD) and the Department of Veterans Affairs (VA). The center houses specific suicide-prevention data, statistics, programs and resources organized for veterans, families and the community.

Also in September 2013, The American Legion released a report titled "*The War Within*"⁶ which included findings and recommendations based on three years of comprehensive research by The American Legion's PTSD/TBI Committee. The key findings from the report include:

- *VA and DOD have no well-defined approach to the treatment of TBI*
- *Providers are merely treating the symptoms*
- *DOD and VA research studies are lacking for new non-pharmacological treatments and therapies such as virtual reality therapy, hyperbaric oxygen treatment, and other complementary and alternative medicine (CAM) therapies.*

The report recommended that Congress increase DOD and VA budgets to improve the research, screening, diagnosis, and treatment of TBI and PTSD, as well as accelerate their research efforts to properly diagnose and develop evidence-based treatments for TBI and PTSD.

At a House Veterans Affairs Committee hearing last April, then National Commander Daniel M. Dellinger told Congress that Department of Veterans Affairs (VA) leadership must be held accountable for mistakes that result in preventable deaths at its medical facilities. At the Atlanta VA Medical Center, Past National Commander Dellinger outlined the organization's most serious concerns:

"[T]wo veterans died of an overdose, and one committed suicide, that was attributed to mismanagement and an inability to get the mental health care they needed in a timely manner. Veteran suicides continue to plague our nation at 22 per day, with no clear strategy from VA on addressing suicides proactively. Veterans with traumatic brain injury and post-traumatic stress disorder are being overprescribed with medications, and VA is demonstrating reluctance toward looking at complementary and alternative medicine because giving out pills is faster than providing veterans the therapy sessions they need. Servicemembers returning to civilian life are falling through the cracks due to [DOD] and VA's inability to create a single, interoperable medical record".⁷

⁶ *The War Within*

⁷ *House Committee On Veterans Affairs :A Continued Assessment of Delays in VA Medical Care and Preventable Deaths- April 9, 2014*

Also last April, The American Legion submitted testimony for the record to a Senate Committee on Veterans' Affairs hearing entitled *Overmedication: Problems and Solutions*. In testimony, The American Legion stated:

*"There are no single treatments guaranteed to cure all ailments. With a national policy that respects and encourages alternative therapies and cutting edge medicine, veterans have the best possible shot to get the treatment they need to continue being the productive backbone of society their discipline and training prepares them to be."*⁸

The American Legion believes all possibilities should be considered in the attempt to find treatments and cures for these conditions affecting significant numbers of veterans, including alternative medicine. If alternative medical treatments are shown to be effective than those treatments should be made available to all veterans.

That is why in April 2015, The American Legion testified in support of H.R. 271: The Cover Act, which would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

However, problems within VA continue. Based on a clinical review at the Tomah VA medical center, patients were 2.5 times more likely than the national VA average to be prescribed high dose opioids. Additional details showed patients at Tomah were prescribed benzodiazepines and opioids at the same time, a practice known to cause complications, nearly twice as much as other VA medical centers.⁹

Based on a Department of Veterans Affairs Office of Inspector General (VAOIG) report entitled *Alleged Inappropriate Opioid Prescribing Practices Chillicothe VA Medical Center*, VAOIG substantiated that¹⁰:

- VA physicians were not consistently documenting medication effectiveness prior to renewing prescriptions for patients at increased risk for adverse medication effects or diversion.
- VAOIG also found that physicians were not consistently documenting use of the Ohio Automated Prescription (Rx) Reporting System, a state prescription drug monitoring program.
- According to Veterans Health Administration policy, patients on chronic opioid therapy are to be evaluated every 1 to 6 months. Although renewing opioid prescriptions without examining patients is not a violation of law or VA policy, a minimum review of patient information is required. However, VAOIG review of 88 patients for whom opioids were prescribed in 2013 and 2014, and who were at increased risk for complications or abuse

⁸ STATEMENT OF THE AMERICAN LEGION TO THE COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE HEARING ON "OVERMEDICATION: PROBLEMS AND SOLUTIONS"

⁹ weau.com: <http://www.weau.com/home/headlines/Another-VA-scandal-Suspected-opiate-abuse-in-Tomah-Veterans-Affairs-Medical-Center-297280791.html>

¹⁰ VAOIG Report No. 14-00351-53

of opioids, revealed that physicians did not appropriately assess patients before renewing opioid prescriptions.

The results of this report indicate VA still has work to do in terms of evaluating their opiate prescription practices. The American Legion will continue to examine this practice as our Veterans Benefit Centers (VBCs) continue to travel the country interacting with the veterans and VA staff throughout the VA healthcare system.

The American Legion believes that ensuring the health care of our nation veterans who are at risk of suicide is paramount¹¹, which is why The American Legion fully supported the “Clay Hunt Suicide Prevention for American Veterans Act” or the “Clay Hunt SAV Act”, signed into law in February. Under this act, the VA and DOD are required to review their mental health care programs annually to ensure their effectiveness, offer special training on identifying those veterans who are at risk of suicide to their mental health providers, and to improve the process regarding medical records and prescriptions to ensure seamless care to transiting servicemembers. This act also requires DOD and VA to submit to independent reviews of their suicide prevention programs and make information on suicide prevention more easily available to veterans. It also offers financial incentives to psychiatrists and other mental health professionals who agree to work for the VA and help military members as they transition from active duty to veteran status. This is a first step towards creating a better treatment environment for veterans struggling with suicide, but it will require full attention and oversight from Congress and Veterans Service Organizations (VSOs) to ensure it is effectively implemented.

Conclusion

Overuse of opiate prescriptions clearly creates problems for veterans within the VA healthcare system. The American Legion believes more robust use of complementary and alternative medicine will help to alleviate some of those problems, and therefore supports legislation like the COVER Act and others. The entire VA mental healthcare system deserves extra attention as veterans struggle with suicide, and the Clay Hunt SAV Act is a step towards getting it that attention.

VA has begun to address over prescription of painkillers and has increased efforts in support for suicide prevention but they need to continue to partner with veteran service organizations, such as The American Legion to improve outreach. The American Legion is fully committed to work with DOD and VA in providing assistance to increase awareness.

As always, The American Legion thanks this committee for the opportunity to explain the positions and concerns of the more than 2 million veteran members of the nation's largest wartime veterans service organization. Questions concerning this testimony can be directed to Warren Goldstein in The American Legion Legislative Division (202) 861-2700, or wgoldstein@legion.org

¹¹ Resolution No. 196: *Suicide Prevention for American Veterans Act* – AUG 2014

Date: September 28, 2015

Deliverable: HVAC O&I – June 10th Hearing

Background: During the June 10, 2015 hearing, Chairman Coffman asked, “How many physiologists or rehabilitation physicians does the Veterans Administration have, Dr. Clancy?”

Question: How many Physiatrists, Physiologists or rehabilitation physicians does the Veterans Administration have?

Response: Below please find the requested information:

Data Source: PAID data via VSSC ProClarity Data Cube excluding Veteran Canteen Service (VCS), intermittent, non-pay, medical residents, and trainees with assign codes T0-T9, current as of August 31, 2015.

| Occupation | Onboard Employees |
|------------------------------------|-------------------|
| *0413 Physiology | 111 |
| 0602 Physician/13 PHYSIATRY | 118 |
| 0602 Physician/44 PHYS MED & REHAB | 544 |
| Total | 773 |

*Please note there isn't a Physiologist specialty under 0602 Physician. The 0413 Physiology occupation is under the Biological Sciences series. The Occupational Series Title for most of them is Research Physiologist.

Deliverable**HVAC O&I Hearing titled "Circumvention of Contracts in the Provision of Non-VA Healthcare"****June 1, 2015**

Congresswoman Walorski's asked a question regarding a constituent vendor who is no longer eligible for a VA contract for orthotics.

VHA Response:

The VISN 11 Prosthetics Integrated Service Line has been working for some time to move vendors to firm contracts that require a standard level of quality from approved vendors. VISN 11's effort is part of a VHA-wide initiative. The goal of the initiative is to:

- Ensure quality patient care to provide a satisfactory Veteran experience;
- Improve timely Veteran care;
- Assure compliance with Medicare prices.

The VISN's seven (7) medical centers and their CBOC's have been relying on purchase card micro-purchases to fill Veteran prosthetics needs for many years. The Prosthetics Integrated Service Line has used firm contracts to ensure quality, timeliness and price for many years on artificial limbs procurements. This initiative closely aligns the Orthotic procurements with the standards already set for Prosthetics artificial limb purchases via historical contracts and Medicare patient guidelines. It also follows the national accrediting bodies' scope of practice for Orthotic-Prosthetics-Pedorthic patient care.

Leather Banana, the vendor mentioned (unnamed) at the hearing, has provided satisfactory orthotic goods and services in the past to VISN 11. However, Leather Banana is a retail store that sells handbags, wallets, belts, etc. They do not have a certified pedorthist on-site to ensure orthotics are properly fitted and perform in the intended function. Other vendors have been unscrupulous, and provided non-therapeutic shoes in place of diabetic shoes, as one example. This causes a delay in the Veteran's treatment when a new order must be made. Furthermore, the wrong shoe or ill-fitting shoe can lead to an amputation for an at risk Veteran patient.

To be qualified for the advertised contracts, Leather Banana was informed they needed to have a certified Pedorthist on staff. They were unable to meet this requirement even though VHA extended the response date by an additional 30 days at the request of Leather Banana.

The VISN 11 Prosthetics Integrated Service Line decided to create firm contracts with qualified vendors across their region. To be deemed qualified, VISN 11 follows Medicare guidelines for clinical practice, coding and billing. Also, VISN 11 Prosthetics used the national accrediting bodies in orthotics-prosthetics-pedorthics scope of practice for certified clinicians.

VISN 11 Prosthetics decided it was important to allow as many vendors as possible, and manageable, to be eligible to ensure sufficient regional coverage. They selected a minimum quality standard of having a certified Pedorthist on staff. The terms and conditions of the

contracts allow VHA to inspect vendor facilities, review patient records, and billing practices to ensure the vendors stay within the scope of practice established under the contract. VISN 11 Prosthetics has a certified Contracting Officer Representative to monitor each contract. Each Veteran patient order will be paid using the purchase card to minimize the time from VHA consult to vendor order. Some responding vendors have offered prices lower than Medicare rates resulting in savings for VHA.